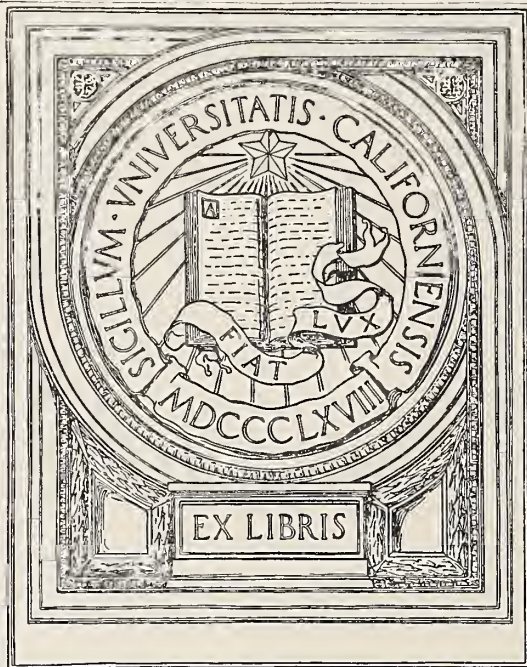


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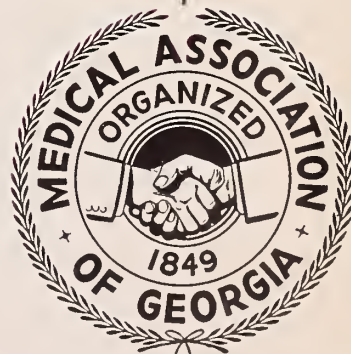
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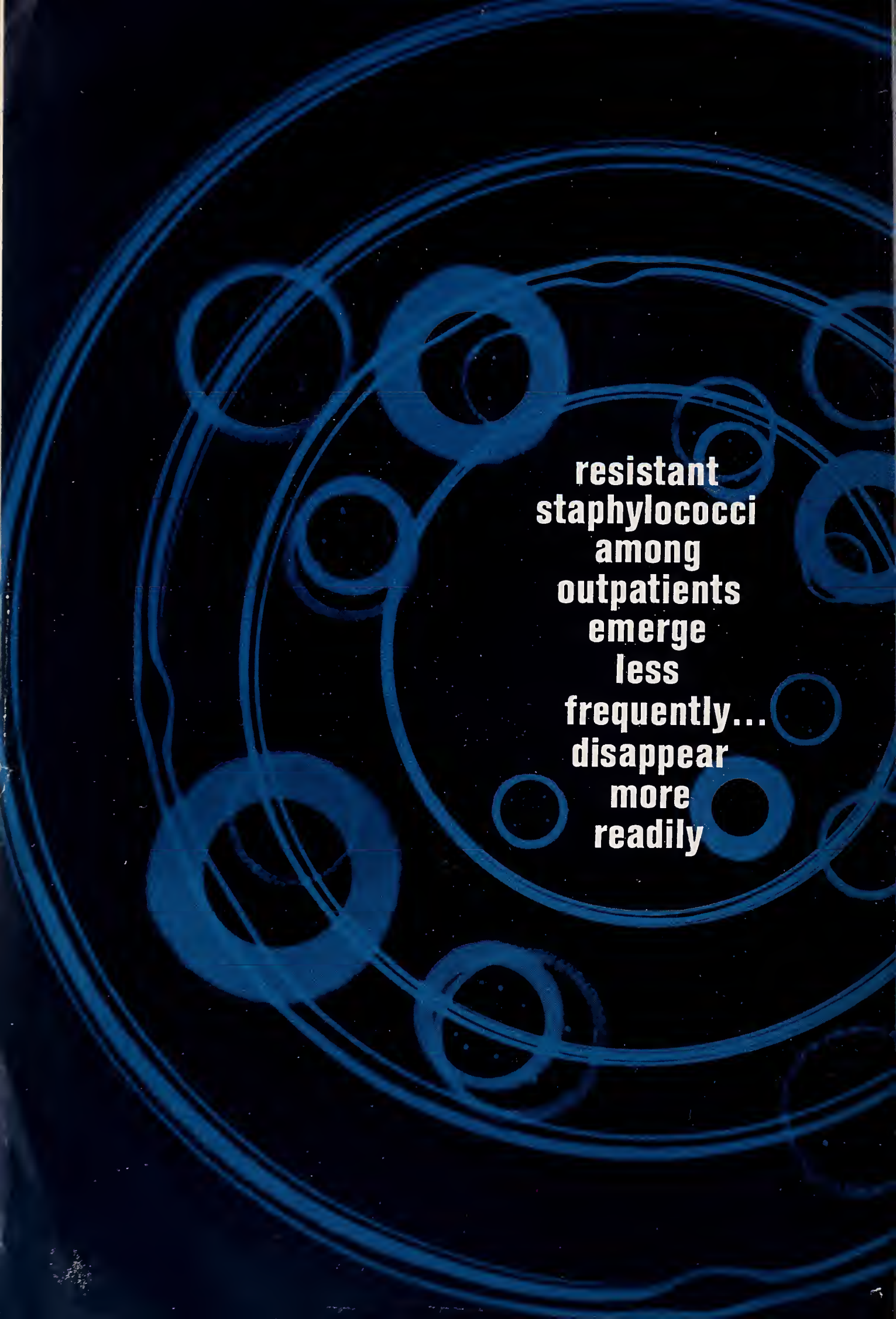
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INTESTINAL OBSTRUCTION OF THE NEWBORN

Calder B. Clay, Jr., M.D., *Macon*

Newer concepts in the surgical management of these problems are presented.

THE AVERAGE PRACTITIONER rarely encounters neonatal intestinal obstruction. Because of this fact, the physician may be unaware of the early findings associated with these various anomalies and diagnosis may be delayed. Delayed diagnosis and treatment often proves to be disastrous in dealing with these infants. The purpose of this paper is to review the subject of intestinal obstruction of the newborn infant placing emphasis on methods of arriving at an early diagnosis and discussing briefly the principles of surgical management.

General Considerations

Tremendous strides have been made in this field since 50 years ago when Fockens⁶ performed the first successful operation for neonatal intestinal obstruction on a case of intestinal atresia. The steady improvement in mortality figures is largely due to earlier diagnosis, better understanding of the physiological needs of the newborn infant permitting better preoperative and postoperative care, better anesthetic techniques, and improved surgical techniques. One cannot give too much credit to Ladd and Gross and their group at the Children's Hospital of Boston who have treated so many of these infants and who have been directly responsible for much of the progress which has been made.

In spite of this progress some of these children are lost due to unavoidable circumstances such as prematurity and multiple congenital anomalies. A great many of these children are born prematurely.

This, of course, compounds the problems which are present in dealing with the full term infant and special care is required. Mortality figures are higher in proportion to the degree of prematurity, but the situation is not usually hopeless. In 1952 Gross¹⁰ presented a paper on his observations in dealing with 159 infants weighing less than five pounds who were operated upon at the Children's Hospital of Boston. Eighty-seven of these babies survived a variety of major surgical procedures. Many of the principles discussed in his article can only be mentioned here. These include the importance of preservation of body temperature; meticulous care of the tracheo-bronchial airway; the judicious administration of oxygen, and the exacting administration of fluids, electrolytes, and blood.

Multiple congenital anomalies occur rather commonly. There may be more than one congenital defect in the gastrointestinal tract or there may be a coexisting defect of the cardiovascular, genitourinary, or central nervous systems. Once neonatal intestinal obstruction is suspected, a careful search should be made for anomalies of other systems. Even though these other anomalies might not preclude surgery for the intestinal obstruction, the physician should be aware of their presence. At the time of operation, it is extremely important that all obstructing lesions be dealt with and operation is not complete without careful search for other possible lesions.

Diagnosis

There are certain findings which occur in varying degrees in the newborn child which should alert the physician to suspect intestinal obstruction. Once the condition is suspected, the diagnosis can usually be confirmed by physical examination and simple flat

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and upright abdominal x-rays.

It is not generally appreciated that *polyhydramnios* occurring in the mother often signifies an intestinal obstruction of the fetus. This fact has recently been emphasized by Clatworthy³ who found this condition to exist in 45 per cent of his patients who had duodenal or high jejunal obstruction. A high percentage of his cases with esophageal atresia were also associated with this condition. Polyhydramnios is rarely associated with low intestinal obstruction, apparently because the increased absorptive surface of the intestinal tract allows absorption of the amniotic fluid with transfer via the fetal blood stream to the blood stream of the mother. The presence of polyhydramnios should alert the obstetrician to the possibility of some obstructive lesion in the infant.

Bile stained vomitus almost always signifies intestinal obstruction in the newborn infant. While the spitting up of mucous or small amounts of feedings is commonplace, the presence of bile in the vomitus is definitely abnormal. If this fact alone could be stressed to all nursery personnel, many cases of neonatal intestinal obstruction would be diagnosed earlier. With a high obstruction such as duodenal atresia, vomiting appears early, usually within the first 12 to 24 hours. With obstruction of the lower small bowel or colon, vomiting usually appears by the second day. If allowed to progress, vomiting becomes more profuse and tremendous amounts of fluid and electrolytes can be lost in a relatively short period of time.

Most of these infants show some degree of *abdominal distention*. This may be present at birth or more likely it will develop during the first 24 to 48 hours. With low obstruction, the distention will be generalized and is usually quite severe. With high obstruction, the distention may be localized in the epigastrium, or in rare cases distention may not be apparent. Visible peristaltic waves or intestinal patterning may also be observed.

Abnormal stools are another important factor in establishing a diagnosis of neonatal intestinal obstruction. The normal infant usually passes a meconium stool within the first 24 hours. Failure to pass one within 36 hours should certainly alert the physician to the possibility of an intestinal obstruction. If a complete obstruction is present, the child obviously cannot pass a meconium stool. If a stool is passed, it is apt to be a small, inspissated, grayish or gray-green mucous stool. If the obstruction is incomplete, the child may pass meconium stools or even milk curds but the stools are usually scanty. In all cases of neonatal obstipation, a digital rectal

examination should be done to rule out rectal obstruction. Occasionally, this examination may be rewarded by the passage of a constipated meconium stool.

Once intestinal obstruction is suspected, *flat and upright abdominal x-rays* should be obtained without delay. Ordinarily, these simple exposures will provide the diagnosis. It should be remembered that during the final months of gestation, the fetus is continually ingesting and assimilating amniotic fluid.³ In cases of high grade intestinal obstruction, there may be extreme degrees of dilatation and hypertrophy of the proximal segment of the intestine while the distal segment will be small, empty, and thin-walled. These changes are present at birth. Wasch and March²⁷ have demonstrated by x-ray studies that after birth, air reaches the duodenum within minutes and the cecum within three to eight hours. Taking these factors into consideration, one can see how the plain x-ray, even several hours after birth, will usually demonstrate the level of obstruction.

Though rarely indicated in cases of total high obstruction, in some cases of partial high obstruction it will be necessary to instill a radiopaque material in the stomach in order to establish a diagnosis. Some authorities feel that an iodized oil should be used instead of barium in order to avoid possible complications of aspiration or even possible post-operative difficulties at the point of intestinal anastomosis. Hope and O'Hara¹² have pointed out that air makes an excellent contrast medium. In certain cases of high obstruction where there is a large amount of fluid present in the stomach or duodenum, or when these organs have been emptied by vomiting, aspiration of fluid and injection of a small amount of air through a small gastric tube will usually show the point of obstruction. In all cases of low intestinal obstruction, a barium enema should be performed. X-ray findings will be discussed further in considering the various types of obstruction.

Preoperative Case

Once the diagnosis of intestinal obstruction has been established in the newborn infant, a small polyethylene gastric tube should be inserted. Frequent aspiration with a syringe will prevent vomiting and aspiration. A small polyethylene catheter is inserted into an ankle vein to permit administration of fluids, electrolytes, and blood as required. Antibiotics should be administered routinely because of the ever present danger of atelectasis, aspiration pneumonia, or peritoneal soilage. Vitamin K should be administered to avoid the possibility of hypothermia. The child is usually taken to the operating room in an incubator so that it will be available at the completion of the operative pro-



Figure 1: Classical x-ray findings of duodenal atresia showing the "double bubble" formed by the hugely dilated stomach and duodenum and the absence of air distal to the obstruction.

cedure. During the preoperative as well as the post-operative period, the closest of cooperation is required between the pediatrician and the surgeon.

Several anesthetic agents and techniques have been used successfully in the management of these problems. Certainly one would expect a more successful outcome when the anesthetic is administered by a well trained anesthesiologist.

Specific Considerations

In discussing the various congenital obstructions from a diagnostic viewpoint, it is helpful to consider them according to the level of the gastrointestinal tract involved. They may be classified as duodenal obstruction, obstruction of the jejunum and ileum, and colonic obstruction.

The usual *duodenal obstruction* is due to duodenal atresia, duodenal stenosis, peritoneal bands or rarely annular pancreas. The obstruction may be complete or partial. By definition atresia causes complete obstruction while the others are usually partial and may manifest themselves weeks, months, or even years after birth. On the other hand the partial obstruction may be so nearly complete as to simulate a total obstruction clinically.

Duodenal atresia manifests itself very early.

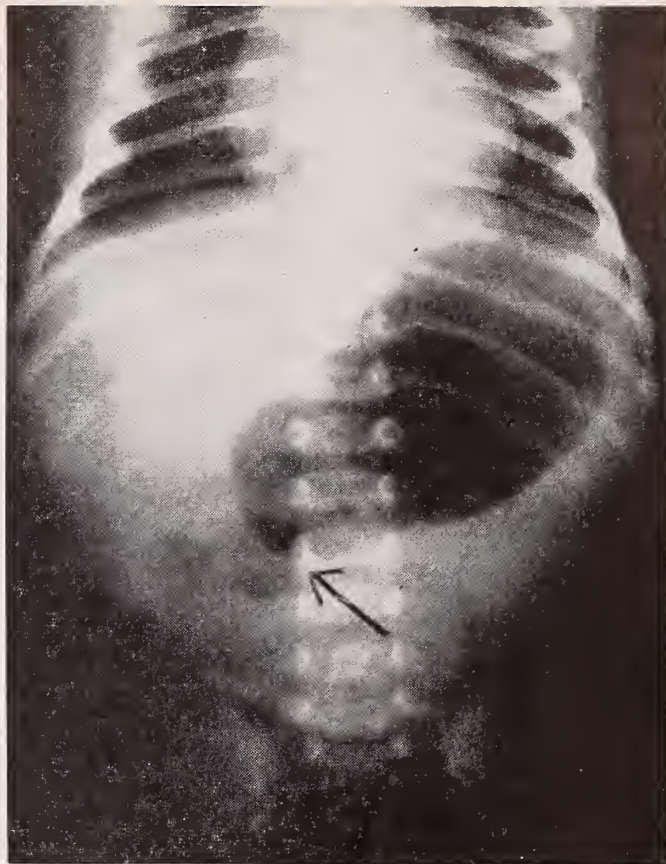


Figure 2: Plain abdominal x-ray of a six-day-old infant with partial duodenal obstruction caused by peritoneal bands associated with malrotation of the midgut. The stomach is dilated and there is trapped air in the duodenum.

Vomiting usually appears within the first 12 to 24 hours after birth. Except in the very rare case where the obstruction is proximal to the sphincter of Oddi,^{7,19} the vomitus will contain bile. Whereas there is usually epigastric distention, the abdomen may actually be scaphoid. Gastric peristaltic waves may be seen in the epigastrium. With complete duodenal obstruction, the child may pass a mucous stool which may be confused with a normal meconium stool. If doubt exists, Farber's test⁵ to determine the presence of swallowed epithelial cells from the vernix caseosa may be helpful. Once total duodenal obstruction is suspected, simple, flat, and upright abdominal films will usually confirm the diagnosis by demonstrating the hugely dilated stomach and duodenum while no air will be seen distal to the point of obstruction (Figure 1). As mentioned previously, in those cases where the stomach and duodenum have been emptied by vomiting, air injected through a gastric tube will usually clarify the situation.

Annular pancreas may cause symptoms during the neonatal period, but usually this condition manifests itself in later life.¹⁷ The time of appearance and severity of symptoms caused by duodenal stenosis or extrinsic obstruction caused by peritoneal bands depend on the degree of obstruction. In Gross's series of cases a majority of the infants with duodenal bands and about half of those with stenosis

INTESTINAL OBSTRUCTION / Clay

developed symptoms during the neonatal period. Often the plain films will provide one with the diagnosis. If not, the instillation of air or iodized oil will usually demonstrate the point of obstruction (Figure 2).

There is unanimous agreement among the authorities as to the proper surgical management of these duodenal anomalies.^{7,8,9,16,20} The intrinsic obstructions are treated by side to side duodenojejunostomy, by-passing the point of obstruction. This also applies to annular pancreas.¹⁷ With atresia, which may vary from a membranous web to a complete absence of a portion of the duodenum, anastomosis of the hugely dilated proximal segment to the collapsed empty worm-like distal segment may be extremely difficult. With partial obstruction, this is less of a problem.

Duodenal bands are usually associated with malrotation and abnormal fixation of the cecum. The peritoneal bands which pass from the cecum across the duodenum must be divided, as described by Ladd,¹³ so that the duodenum hangs caudally from its point of fixation. The cecum is placed in the left upper abdomen. Several authors^{3,8,15,20} have pointed

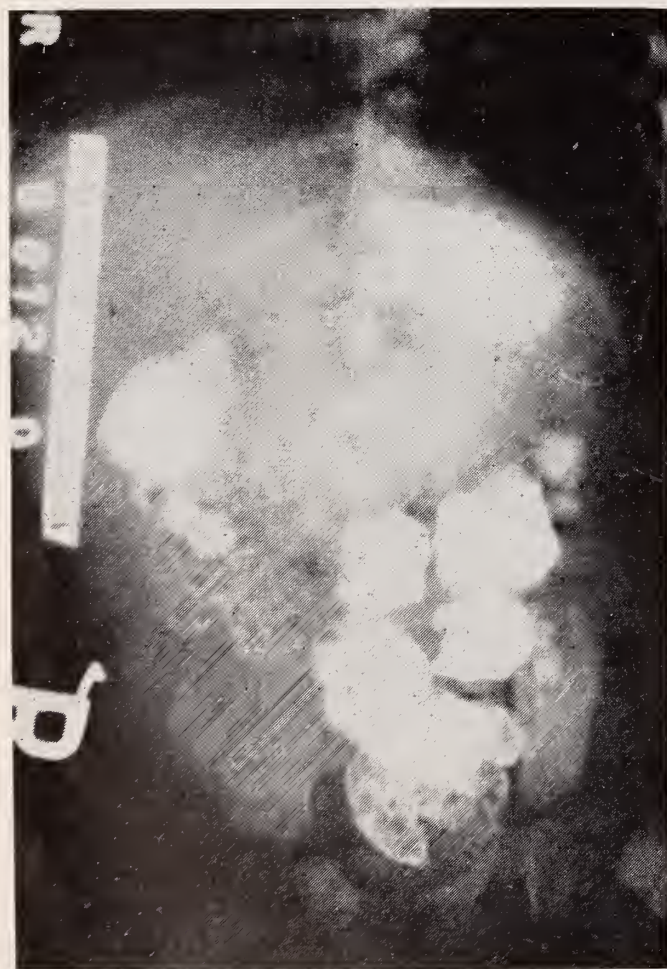


Figure 3: Delayed film taken after instillation of barium into the stomach of a three-week-old infant with duodenal stenosis who had laparotomy with division of para-duodenal bands one week previously. The dilated duodenum can be seen in the left upper abdomen adjacent to the stenotic area. Barium remains in the malrotated colon from previous x-ray examination.

out that duodenal bands may coexist with duodenal stenosis or a duodenal web. After the bands are divided, one should pass a good sized gastric tube through the area to rule out intrinsic obstruction. If the proximal duodenum is widely dilated, some authorities³ suggest opening the duodenum to search for a web or stenosis (Figure 3).

This group of duodenal obstructions can usually be diagnosed early and a majority should be salvaged.

Jejunal and ileal obstruction in the newborn may be caused by atresia, stenosis, volvulus of the midgut, meconium ileus, meconium peritonitis; and less commonly by such conditions as internal hernia, obstruction by tumor or duplications of the intestinal tract.

Atresia or stenosis may occur at any level of the small bowel. There may be multiple areas of atresia. As with duodenal obstruction, the time of appearance of symptoms and the severity of symptoms depend upon the degree of obstruction. Atresia at any level will cause symptoms early while stenosis may not produce symptoms until later. Vomiting is a consistent finding and bile will usually be apparent in the vomitus. If allowed to progress the vomitus may become feculent. Abdominal distention is prominent particularly in the low obstructions. Absent or scanty meconium stools will be present depending on the degree of obstruction.

The plain x-ray will show dilated loops of small



Figure 4: Plain film of a three-day-old infant with jejunal stenosis. No air is seen distal to the dilated proximal jejunum (arrow).

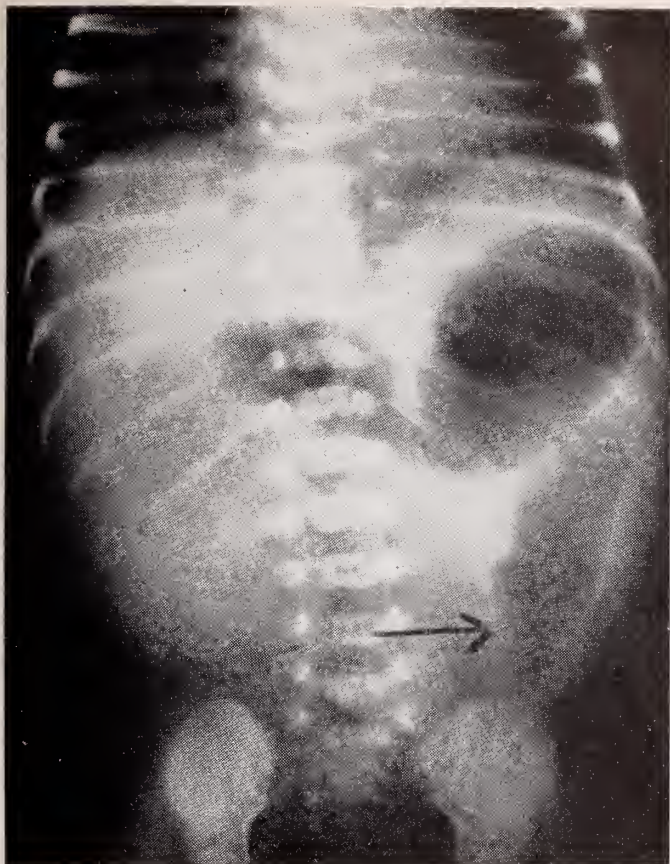


Figure 5: Upright film of a one-day-old premature infant with atresia of the jejunum (arrow). Also had malrotation with volvulus of the midgut and gangrene of most of the small intestine.

bowel (Figure 4). If the obstruction occurs in the lower ileum, it may be impossible to determine whether the dilated loops are small or large bowel (Figure 5). A barium enema should be done in order to clarify this situation.

Whereas opinion regarding the surgical management of duodenal atresia is uniform, there is some difference of opinion among authorities in the management of low small bowel atresia. Gross⁹ has advocated Mikulicz resection of the distended and collapsed segments followed by early closure of the spur. Swenson²⁴ has recommended resection of the more dilated proximal loop with aseptic end to end anastomosis of the two segments of intestine. Clatworthy³ states that he is exploring the possibility of even wider resection of the dilated proximal bowel and the empty distal segment with end to end enteroenterostomy or end to side ileocolostomy. When enteroenterostomy is performed, some form of proximal decompression is of great importance. Miller and Schumacker¹⁶ have improved their mortality rates considerably by performing a proximal tube decompression enterostomy.

Volvulus of the midgut occurs in the infant who has anomalous rotation and fixation of that part of the intestinal tract. It usually occurs in conjunction with partial duodenal obstruction caused by peritoneal bands passing from the malrotated cecum. The small bowel has no mesenteric fixation and may

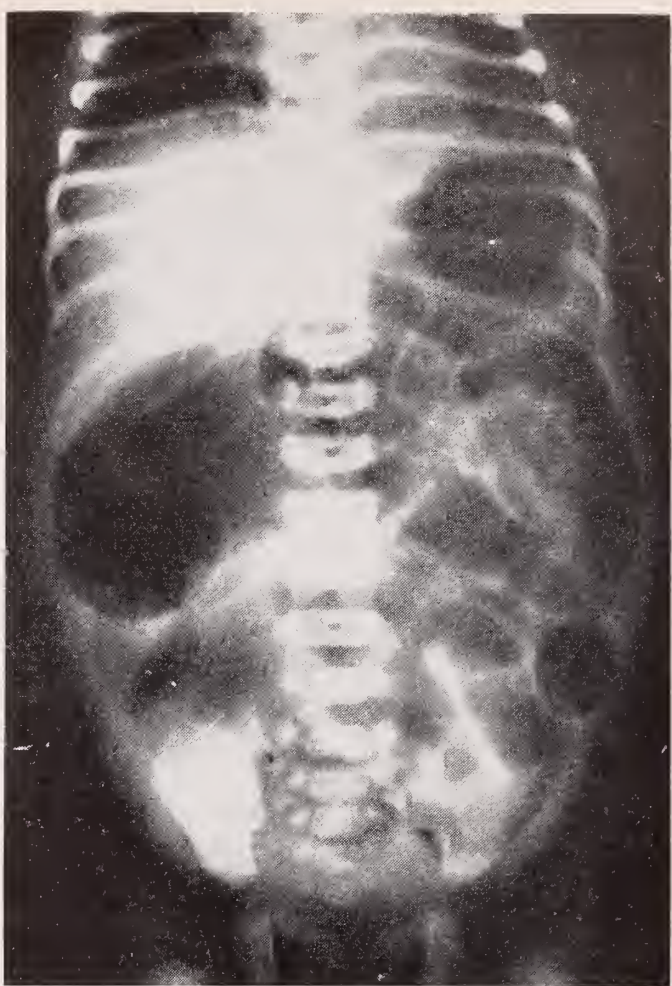


Figure 6: Plain film of a four-day-old infant with atresia of the terminal ileum. Impossible to distinguish small from large bowel.

easily become twisted. The embryology of this condition has been presented clearly in the literature on many occasions.^{9,22} Suffice it to say that the usual infant with malrotation of the intestine who presents symptoms during the neonatal period will show signs of partial duodenal obstruction. If in addition there is a volvulus of the midgut, there will be signs of complete obstruction of the small intestine. If this is allowed to progress to the point of infarction, there may be added signs of massive gangrene of the intestine. Plain x-rays taken early may demonstrate only the proximal point of obstruction with small air bubbles in the remainder of the small bowel (Figure 6). If films are taken after the volvulus has persisted, there may be enormous distention of the twisted small bowel caused by gas forming organisms.

If the diagnosis is not apparent after plain films are taken, the next order of business should probably be the administration of a radiopaque material into the stomach since the signs and symptoms are those of high obstruction. This may demonstrate a partial duodenal obstruction in addition to a complete block at the proximal point of twisting near the duodenojejunal junction. If a barium enema is performed, the abnormal position of the cecum is apparent.

When diagnosed and treated early, these infants should have a good prognosis. The volvulus is reduced and the para-duodenal bands divided.¹³ When the volvulus has persisted to the point of infarction, massive resection of most of the small bowel must be performed, even though the prognosis is extremely poor.

Meconium ileus represents a severe form of the systemic disease of cystic fibrosis of the pancreas or mucoviscidosis. This latter term was suggested by Farber⁴ in 1945 and described a condition characterized not only by pancreatic insufficiency but also by abnormal secretions of all the exocrine glands of the body including the mucous secreting glands of the respiratory and gastrointestinal systems. Due to insufficient production of mucous in the intestinal tract and the insufficient production of pancreatic enzymes, the meconium in these infants is extremely sticky and tenaceous. Plugs of meconium become lodged in the terminal ileum and produce signs of complete obstruction. In addition to the usual findings of low intestinal obstruction, one may be able to palpate the meconium masses in the right lower abdomen. Plain x-ray films demonstrate gaseous distention of the small bowel. The loops often vary greatly in size. Neuhauser¹⁸ has described the foamy or bubbly appearance of the meconium masses and White²⁸ has pointed out that there is a characteristic absence of fluid levels in the distended bowel.

Hiatt¹¹ reported the first successful operation for this condition in 1948 and suggested enterostomy with removal of the tenaceous meconium by irrigation with profuse amounts of saline. Gross⁹ has advocated Mikulicz resection of the occluded loop followed by instillation of pancreatic enzymes into the enterostomy and later closure of the enterostomy. If there is doubt as to the viability of the plugged loop, either this latter procedure or resection with ileo-ileostomy or ileocolostomy should be performed. Potts²⁰ prefers direct anastomosis with instillation of pancreatic enzymes at the time of surgery. If these infants survive their operation, they must receive intensive medical treatment for their systemic disease.

Meconium peritonitis is a rare condition that results from intrauterine rupture of the fetal intestine. This may be associated with an obstructive lesion such as an atresia or meconium ileus or in some cases no obstruction may be demonstrated. If the perforation remains open at birth, bacterial peritonitis soon follows. If the perforation has become sealed, bacterial contamination will not occur. The plastic exudate caused by the spillage of meconium is very apt to cause mechanical small bowel obstruction.

The infant with classical meconium peritonitis is born with marked abdominal distention. The abdominal wall may be reddened and edematous and pit on pressure. Dilated veins may be present in the abdominal wall. Plain x-ray films may show in addition to intestinal distention, the characteristic stippling of calcified meconium scattered over the peritoneal surfaces. As would be expected, prognosis is very poor even if surgery is performed early.

Included in the group of *colonic obstructions* are the meconium plug syndrome, Hirshsprung's disease and imperforate anus. Colonic atresia and stenosis rarely occur.

Inspissated Plugs of Meconium

Clatworthy² has described a group of newborn infants who are born with inspissated plugs of meconium in the transverse or left colon who present classical signs of low intestinal obstruction. He has called this the meconium plug syndrome. Plain x-rays taken within the first few days show distended loops of bowel and, as mentioned previously, it may be impossible to differentiate small and large bowel. Barium enema will demonstrate a small unused colon up to the point of the meconium plug and proximal to this point the colon will be ballooned out. He has been able to treat all these cases by conservative means successfully and none have been associated with mucoviscidosis.

Hirshsprung's disease is not usually considered a problem of the neonatal period. However, during recent years, Swenson,²⁵ Bill,¹¹ and Clatworthy³ among others have reported numerous cases which have presented severe symptoms of low intestinal obstruction during the first week or two of life. Clinically these infants may show marked abdominal distention with obstipation and vomiting. Rectal examination may suggest the diagnosis or the examination may cause the passage of flatus or fecal material. Plain abdominal x-rays will show marked gaseous distention and here again it may be impossible to differentiate small from large bowel. Barium enema will usually establish the diagnosis by showing that the aganglionic distal colon is narrowed and the proximal normal colon is distended. Biopsy of the rectal musculature showing the absence of ganglion cells in the myenteric plexus as described by Swenson²³ will confirm the diagnosis. Rare cases have been reported in which there is agangliosis of the entire colon.¹ Undoubtedly, many of these infants have been subjected to fruitless exploratory procedures in the past with the mistaken diagnosis of small bowel obstruction. By applying the aforementioned diagnostic techniques, this can usually be avoided. Ordinarily these infants can be temporarily



Figure 7: Lateral x-ray taken in inverted position of a one-day-old infant with imperforate anus showing a defect of several centimeters.

relieved of their symptoms by the use of rectal tubes and enemas. Due to the high mortality of medical management in treating these infants with this severe form of Hirschsprung's disease, a colostomy should be performed proximal to the aganglionic segment as soon as the diagnosis is made.²⁵ Resection of the aganglionic segment is delayed until the infant is older.

Imperforate anus is a common anomaly requiring surgery during the neonatal period. Various classifications of this malformation have been offered.^{1,9} Simple observation of the infants' perineum will establish the diagnosis in the majority of cases. Briefly, a small percentage of these children are born with a membranous obstruction which can be diagnosed easily. Another small percentage may have a normal anal opening, but an actual atresia of the colon a few centimeters above the anus. These cases can be diagnosed by digital rectal examination. There is a third small group which show stenosis of the anus. By far the most common and most important group is that variety where there is no anal opening and the proximal bowel ends blindly at varying distances from the anal dimple. This type of imperforate anus is frequently associated with a fistula between the blind pouch and the genitourinary system. In the female, if a fistula is present, it will pass to the vagina or perineum. Often this type of fistula is large enough to allow the passage of gas and feces and the abnormality may not be detected

until later life. In the male, the fistula will usually communicate with the bladder or urethra.

The membranous or stenotic varieties are simply treated and the results are good. The common form of imperforate anus is treated by a perineal or abdominoperineal approach according to the distance of the blind pouch from the anal dimple. This distance is determined by obtaining an x-ray with the infant in the inverted position as described by Wangenstein and Rice.²⁶ If this distance is 1.5 centimeters or less, the perineal approach is used. If this distance is greater, the abdominoperineal pull-through procedure first described by Rhoads²¹ is used (Figure 7). If the infant is premature or if the condition is precarious, a simple sigmoid colostomy is performed and the pull-through operation performed later.

Summary

The subject of intestinal obstruction occurring in the newborn child has been reviewed. Particular reference has been made to the methods of arriving at an early diagnosis which is vital in the successful management of these anomalies. Newer concepts in the surgical management of these problems have been briefly discussed.

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TRANQUILIZING DRUGS

A review of the history of man's search for the ideal tranquilizer is presented.

Morgan E. Scott, M.D., *Atlanta*

HOMEOSTATIC MECHANISMS OPERATE in the average individual to allay anxiety and to limit depression under ordinary stress. In mental illnesses and times of stress, these mechanisms fall short of needs. In either instance, man has sought relief by various means in an attempt to attain tranquility. The first known agent used to attain relief is alcohol. Noah has been described as the first known alcoholic. So we can be sure that the search for relief has extended far back into recorded history. Many adverse factors prevent alcohol from being ideal, the most important being its habit-forming qualities. The tendency of alcohol to release inhibitions in individuals with repressed emotions makes it of little use to the mentally ill.

The opiates, although appearing ideal as short-term hypnotics, were found of little use in psychiatric cases because of their high addiction probability. In 1863 Bayer introduced barbiturates and, although useful still in psychiatry, this group fell short of the ideal because of dosage requirements, side-effects, and habit-forming qualities. Bromides were introduced by Ballard in 1926 and their introduction was followed by glowing reports in the literature of their usefulness in quieting the disturbed individual. Some of these reports sound almost identical to present reports that appear in praise of a particular drug. The toxicity of bromides (with bromism) soon cooled the ardor of these enthusiasts.

The Phenothiazines

During the period 1952-1953, Delay and Deniker introduced the phenothiazines and at approximately the same time Bein introduced reserpine. Since that time, well over 6,000 articles have appeared in journals, most of these proclaiming the virtues of a

particular one of the reserpine or phenothiazine group. The glycerol group (notably, meprobamate) has also met with wide acclaim and the laity as well as the medical profession has used this drug (or abused this drug) extensively since its introduction. The diphenyl methane derivatives—hydroxyzine (Atarax®), benactyzine (Suvatil®), and pipradol (Meratran®) have also received acceptance, although not as popularly as the preceding groups. It would serve no purpose, even if possible, to review the many reports of these various drugs. However, this article will attempt to summarize the reports of many investigators and to classify the most important of these drugs as to their efficacy, side-effects, and chemical grouping. From the mass of studies compiled, certain evidences support the superiority of these tranquilizers over barbiturates, bromides, and other sedatives, namely:

1. No appreciable addiction has been discovered except with the meprobamate group.
2. The side-effects from long-term usage has been minimal or reversible in most cases.
3. Selective sedation has been produced with limited interference with vital processes such as respiration, blood pressure, and physiological consciousness.

Meprobamate Compared to Secobarbital

More recent studies⁴ have refuted the concept of tranquilization being different from sedation when meprobamate was compared to secobarbital. These studies assessed the effects of oral medication (meprobamate and secobarbital) by double blind technique on the parameter of physiological functions, level of consciousness and alertness, psycho-

CHART I

TRANQUILIZERS 1, 3

DRUG	SIDE EFFECTS		DOSAGE
	EFFECTUALITY	TOXICITY	
	1 — good 2 — fair 3 — poor	A — mild B — moderate C — severe	
I. PHENOTHIAZINE GROUP			
A. Aliphatic "tail" Chlorpromazine (Thorazine®)	1B — Jaundice, liver damage, agranulocytosis, urticaria, contact dermatitis, photosensitivity, GI syndrome, Parkinsonism, akathisia, convulsive seizures, depersonalization, depression, hypotension, drowsiness, fatigue, and cataleptic seizures reported. Possibility of liver damage warrants greatest caution.		25-50 mg. qid
Promazine (Sparine®)	2B — Same side effects as chlorpromazine. Less photosensitivity and jaundice but higher incidence of seizures.		50-250 mg. tid
Triflupromazine (Vesprin®)	2B — Relatively new. Agranulocytosis already reported. More data needed.		100-150 mg. daily
B. Piperidine "tail" Mepazine (Pacatal®)	2C — Same side effects as chlorpromazine, but possibly more agranulocytosis, seizures, and atropine-like action. Regarded by some as ineffectual and too toxic for general use.		25-50 mg. tid
Thioridazine (Mellaril®)	2A — More data needed.		25-200 mg. tid
C. Piperazine "tail" Prochlorperazine (Compazine®)	2B — Fewer side effects than chlorpromazine, but higher incidence of Parkinsonism, akathisia, dyskinetic syndrome.		5-30 mg. tid
Perphenazine (Trilafon®)	2B — Fewer side effects than chlorpromazine, but marked akathisia and dyskinetic syndrome as well as convulsive seizures, cataleptic attacks in children and galactorrhea and angioneurotic edema. Relative effectuality: controversial: regarded as equal to chlorpromazine by some.		2-6 mg. tid
Trifluoperazine (Stelazine®)	2A — Fewer side effects than chlorpromazine. Parkinsonism, akathisia, dyskinetic syndrome, agitation, and turbulence prominent — mostly controllable by anti-Parkinsonism drugs or reducing dosage. Further data needed.		1-8 mg. tid
Thiopropazate (Dartal®)	2B — Parkinsonism, akathisia and dyskinetic syndrome prominent. More data needed.		2-10 mg. tid
II. RAUWOLFIA			
Reserpine (Serpasil®)	2B — Jaundice and agranulocytosis not reported. Skin reactions, Parkinsonism, akathisia, dyskinetic syndrome, seizures, depression with suicidal ideation, depersonalization, hypotension, drowsiness, fatigue, excitement, edema, and rupture of peptic ulcer reported.		0.5-1 mg. tid
Deserpine (Harmony®)	3B — Fewer side effects claimed than with reserpine. Further data needed.		0.24-2 mg. tid
Rescinnamine (Moderil®)	3B — May be as effectual as reserpine, but with fewer side effects. Further data needed.		0.25-0.5 mg. tid
III. DIPHENYLMETHANE DERIVATIVES			
Benactyzine (Suavitil®)	3B — Contraindicated in "hostile" patients. May produce concentration difficulty, depersonalization, paresthesias, muscle weakness, dizziness, tension, nausea, vomiting, dry mouth, diarrhea, ataxia, palpitation, apathy, indifference. Recently combined with meprobamate (Deprol®) as an antidepressant-rating #3B.		1-3 mg. daily
Hydroxyzine (Atarax®)	3A — Of questionable value except in very mild anxiety. No side effects yet reported.		10 mg. tid
IV. GLYCEROL DERIVATIVES			
Meprobamate (Miltown®, Equanil®)	2B — No convincing studies demonstrating the superiority of tranquilizers to barbiturates. Meprobamate medication associated with production of fever, malaise, nausea, vomiting, headache, increased peristalsis, cardiac dysrhythmia hypotension with shock, rashes, angioneurotic edema, purpura, itching, drowsiness, euphoria, restlessness, hypomanic conditions, diplopia, and coma. Addiction and withdrawal syndromes reported. Potentiates alcohol barbiturates and antihistamines.		200-400 mg. tid

#1—Am. J. Psychiat. 116: 4, 1959.

#3—Leo E. Hollister, M.D., FACP, Veterans Admin. Hosp., Palo Alto, Calif., Ann. Int. Med. 51: 1032 (Nov.) 1959.

motor performance, mental functioning, subjective effects, behavior during psychiatric interviews, and concluded that sedation and tranquilization are similar states. An additional conclusion was that the main differences lay in the dosage margins between sedative effect and differential effect on alertness, psychomotor performance, mental functioning, and physiological function. Other studies of similar type seem to be suggested for other tranquillizers (phenothiazines and diphenyl methane) and sedatives.

Most Widely Used Tranquilizers

Chart I is an attempt to present a prospective of the most widely used tranquilizers. Many other related tranquilizers are omitted for consideration of space. Most of these related compounds vary in name only. Several points are made clear by a chart of this sort. First, there is no perfect drug (no 1A). When effectuality and toxicity are rated, effectiveness is determined by the ability of the drug to control aggressive behavior and anxiety. The toxicity of a drug is rated as mild to severe on the basis of reversibility of side effects and danger of producing death or serious impairment of vital processes.

Increased Dose Increases Side Effects

Another conclusion that seems valid from comparisons of drugs is that increased milligram dose effectiveness increases side effects such as Parkinsonism, while reducing other side effects such as jaundice or agranulocytosis.

The preceding chart attempts to summarize the effectiveness and toxicity of various tranquilizers. Among the largest single study of tranquilizers is that completed by the Veteran's Administration in their recently reported cooperative study.² Certain conclusions were derived from their study, namely:

1. Chlorpromazine was shown to be superior to promazine in the over-all reduction of symptomatology. In our summary we rate Thorazine® 1B as compared to Sparine® 2B.
2. Four phenothiazines: chlorpromazine, prochlorperazine, triflupromazine, and perphenazine, comparable to our chart, were demonstrably more effective than one, mepazine, 2C in our chart, although all five were clearly superior to phenobarbital in reduction of total morbidity.

3. There were no significant differences among the four more effective drugs, even though the difference shown between prochlorperazine and triflupromazine may appear to approach significance.

It appears then that results of the V. A. studies are consistent with the data given in Chart I.

Conclusions which appear to be supported by these studies are that drugs are useful in controlling aggressive behavior and anxiety. As far as methods of usage, it appears that tranquilizers may be used as: (1) supportive, where they facilitate a relationship or dynamic therapy, or as (2) suppressive, where they suppress symptoms and maintain control of the individual. No valid studies are available at this time as to the long-term superiority of the suppressive or the supportive role of these drugs. Certainly such a study would be suggested by the various dissenting opinions that exist concerning use of these drugs in psychiatry.

Summary

A brief historical review of the history of man's search for the ideal tranquilizer is presented. The introduction of the four main groups of modern sedatives is mentioned. A chart of comparisons of the most widely used drugs has been included. Methods of usage of tranquilizers are (1) supportive and (2) suppressive. Further study is suggested for the effectiveness of long-term comparison of methods of usage.

Recent evaluation of meprobamate when compared in six parameters shows no difference in sedatives as compared to tranquilizers except in dosage margin affecting psychic states and physiological functions. Further similar studies are suggested for other tranquilizer groups.

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Medical Association of Georgia—107th Annual Session

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THE SURGICAL TREATMENT OF CEREBRAL VASCULAR INSUFFICIENCY

*Recurrent focal cerebral ischemic attacks are
frequently associated with stenotic lesions.*

Milton F. Bryant, M.D., *Atlanta*

THE REPORT IN 1954 of Eastcott, Pickering, and Rob¹ on the reconstruction of the internal carotid artery in a patient with intermittent attacks of hemiplegia stimulated many surgeons to consider the problems of cerebrovascular insufficiency. Considerable experience has now been accumulated which shows that approximately 20 to 30 per cent² of patients with cerebrovascular insufficiency have stenotic or occlusive lesions in the extracranial portion of one or more of the four major arteries that supply the brain.

For all practical purposes atherosclerosis is the usual cause of these obstructive lesions, although on occasions, one may encounter embolic obstruction or obstruction due to arteritis. The atherosclerotic lesions have a distinctive topography. It has been recognized for some time that atherosclerosis frequently occurs at sites where major arteries branch. DeBakey and associates³ have described two patterns of involvement, namely a proximal and a distal form. The first form occurs in the proximal portion of the major vessels as they originate from the aortic arch. The atherosclerotic process may involve one, two or all three of the major arterial branches, and the obstruction may be complete or incomplete. It is important to realize that all of these patients have a patent extracranial arterial segment located distally. This means that from a technical standpoint a reconstructive procedure can always be carried out. In the distal form of this disease the plaques are located in the vertebral and internal

carotid arteries at their origin. Early in the course of atherosclerosis the plaques gradually increase in size so as to produce stenosis. Complete obstruction occurs not by accumulation of atherosclerotic material but by acute thrombus formation. Transient symptoms frequently occur with stenotic lesions, whereas permanent neurological deficits are usually associated with complete obstruction to blood flow. The actual blood flow through a vessel conforms to Poiseuille's Law.

$$Q = \frac{(P_1 - P_2) \times A^2}{L \times V \times 8\pi}$$

One can see that if all the other factors in the equation remain constant the flow through a cylinder is in direct proportion to the square of the cross sectional area. As the plaques increase in size the flow decreases. The cause of thrombus formation on an atherosclerotic plaque is still open to debate. The work of Eberth and Schimmelbusch published in 1888 is interesting to read, since very little knowledge has been added to their original observations.

Clinical Features

A stroke is defined as a sudden, focal neurological deficit, due to blockage or rupture of a blood vessel. The deficit does not have to be motor or sensory, although the lay public usually thinks of a stroke as being associated with sudden paralysis. Stenosis or blockage of arteries supplying the brain leads to ischemia or infarction of the territory supplied by

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the involved artery. The presence or absence of collateral circulation through the circle of Willis or through the subarachnoid interarterial anastomoses greatly influences the neurological changes that occur following occlusion or stenosis of the major extracranial arteries. The site and number of arteries involved will influence the clinical picture. Crawford and associates⁴ state that multiple lesions are present in 43 per cent of patients.

Proximal Obstructions

As previously mentioned, proximal obstruction produces arterial insufficiency in the vessels to the upper extremities and to the brain depending upon the number of arteries involved at the aortic arch. The symptoms in the upper extremities are typical of intermittent claudication—absence of pain or discomfort at rest, commencement of discomfort with exercise, intensification of symptoms until exercise is impossible, and disappearance of symptoms with rest. The cerebral symptoms are usually transient in nature and include headache, dizziness or vertigo, visual field disturbances, and fleeting motor and sensory disturbances.

The important physical findings are related to

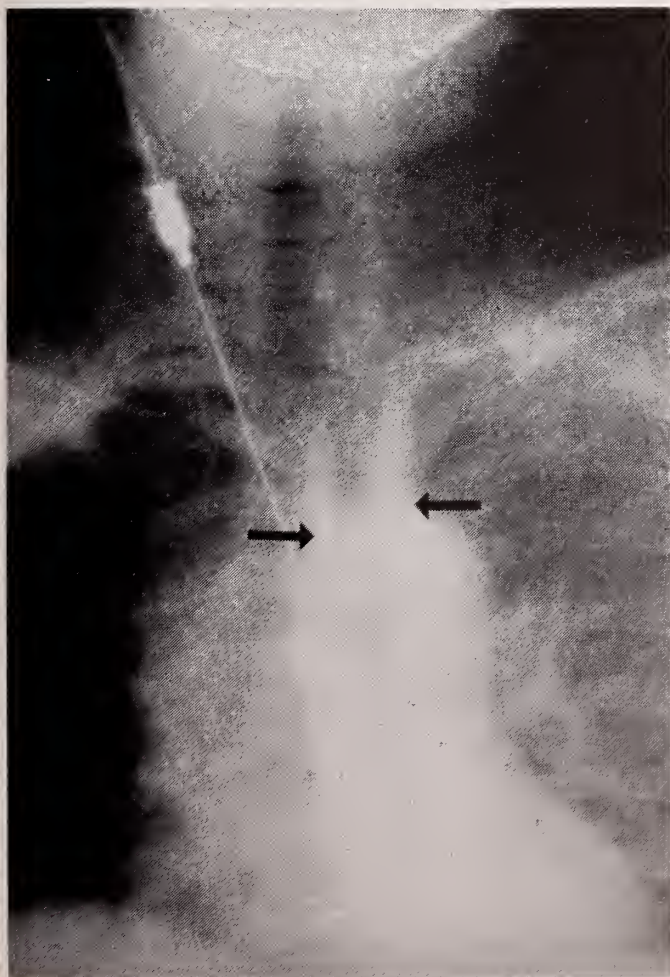


Figure 1: Arteriogram made by direct percutaneous puncture of the aortic arch through the space of Burns. Severe stenosis of the proximal one inch of the left common carotid and subclavian arteries is noted.

examination of the blood vessels in the upper extremities and neck—absent or decreased arterial pulsations, variations of blood pressure in the upper extremities, and with stenotic lesions a loud, continuous murmur can be heard in the suprasternal notch.

The presence of proximal obstructions in the major arteries can be localized clinically, but in order to determine the extent and exact location of these lesions, aortography by direct percutaneous puncture of the aortic arch or by the technique of Robb and Steinberg⁵ is indicated. If symptoms warrant an operation, all of these lesions can be corrected by endarterectomy by the by-pass technique.

This patient (Figure 1) had symptoms of transient cerebral ischemia involving the territory of the left middle cerebral artery and symptoms of intermittent claudication in the left upper extremity. Arterial continuity was restored by splitting the sternum, placing a vascular clamp obliquely across the aortic arch, and performing an endarterectomy. This patient has been well and free of symptoms since her operation one year ago.

Distal Obstructions

This form of extracranial occlusion is located in the proximal portion of the internal carotid artery at the site of its origin from the common carotid artery or in the vertebral artery at its origin from the subclavian artery.

(A) Obstructions in the Internal Carotid Artery

Obstructions in the internal carotid artery usually produce symptoms and signs associated with insufficiency to the territory supplied by the middle cerebral artery. The neurologic features may be transitory or permanent. The most common findings are contralateral hemiparesis or hemiplegia and contralateral sensory defects. If the lesion is on the dominant side of the brain, aphasia will occur and on the nondominant side, minor agnosias. The territory supplied by the middle cerebral artery is large and depending upon collateral flow one may get restricted neurological deficits such as monoparesis or aphasia. Experience has shown that recurrent focal cerebral ischemic attacks (often called small strokes by the layman) are frequently associated with stenotic lesions whereas a full blown, fixed neurologic deficit is usually associated with complete occlusion. One would like to make the diagnosis before complete occlusion and possible permanent cerebral damage. Monocular blindness has been stressed as an important feature of internal carotid artery occlusion, but in actual practice one rarely encounters this feature.

The physical findings associated with obstructions in the internal carotid artery vary and are related to

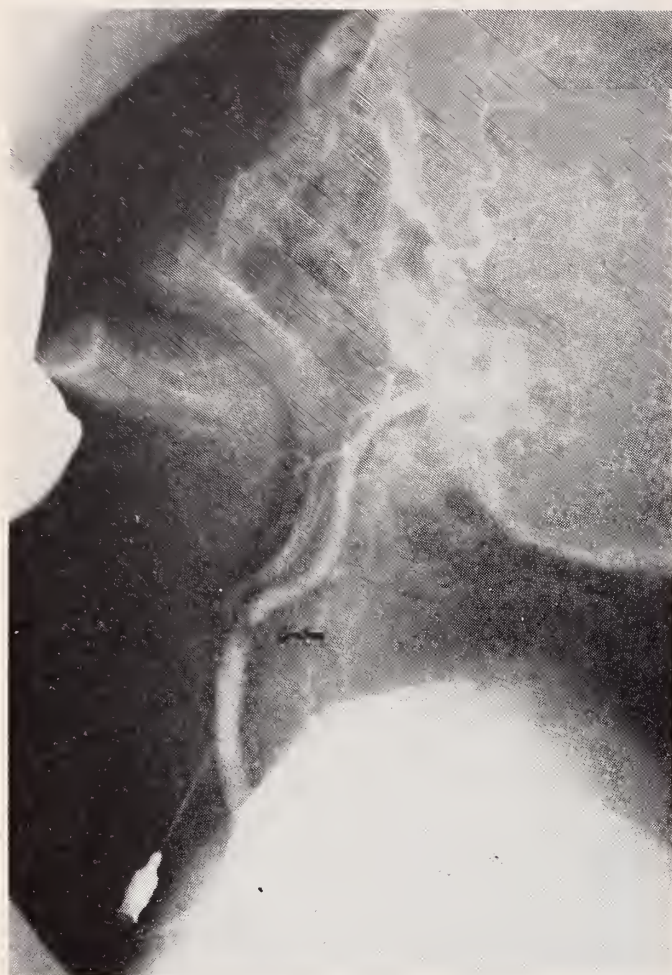


Figure 2: Carotid arteriogram showing segmental stenosis of the internal carotid artery.

abnormalities in the blood vessels and to the resultant damage to dependent brain tissue. A systolic or continuous murmur may be heard over the involved carotid bulb and contralateral digital compression of the common carotid artery may cause syncope—Matas test. The arterial pulsations are usually normal and forceful in the neck, face, and pharynx. The absence of pharyngeal artery pulsations has been mentioned as an important sign in obstructions in the internal carotid artery. Since the external carotid artery is usually patent and since the external and internal carotid arteries are in juxtaposition in the pharyngeal region, the absence of pharyngeal fossa pulsations is seldom encountered. Ophthalmodynamometric studies are occasionally helpful in determining the site of obstruction; however, large anastomotic channels between the external carotid artery and the ophthalmic artery frequently make this study inconclusive. Lumbar puncture is helpful in differentiating acute occlusive disease from intracranial hemorrhage.

Many workers feel that the limitations in diagnosing and differentiating occlusions in the extracranial portion of the internal carotid and vertebral arteries from occlusions in the intracranial divisions of these

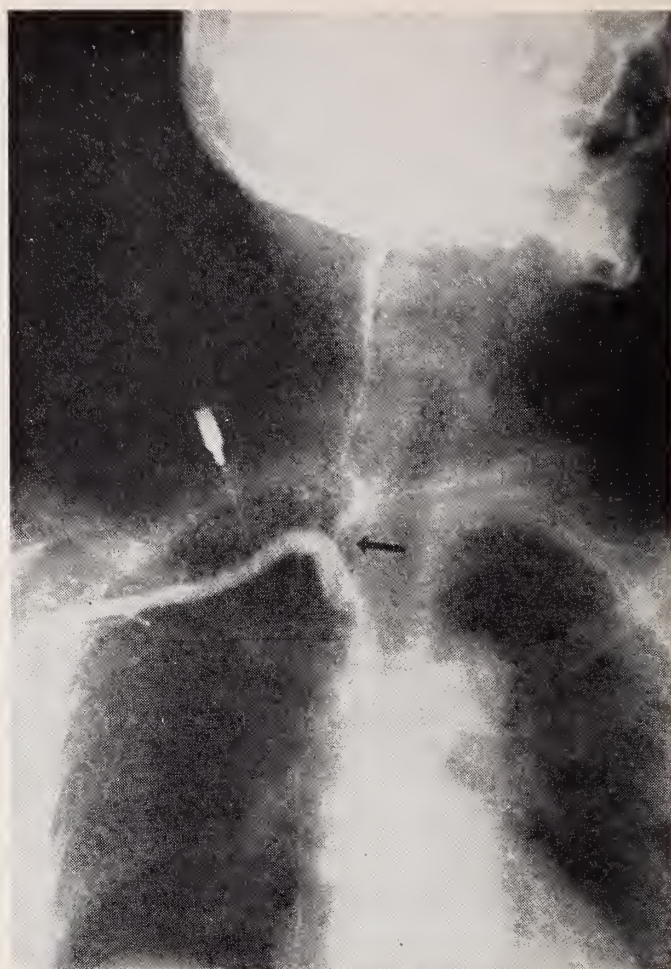


Figure 3: Trans-subclavian vertebral arteriogram showing marked stenosis at the origin of the vertebral artery. The opposite vertebral artery was completely occluded.

vessels is so marked that all patients with cerebral vascular insufficiency should be evaluated by arteriography. Both carotid arteries should be visualized and due to the multiplicity of lesions it may be helpful to study at least one and possibly both vertebral arteries.

Patients with symptoms of cerebral vascular insufficiency due to segmental atherosclerotic lesions in the base of the internal carotid artery can frequently be treated by thromboendarterectomy alone, thromboendarterectomy and patch graft or with a by-pass graft. In actual practice one seldom uses a by-pass graft. An internal or external shunt is usually not necessary unless the opposite carotid artery is occluded or stenosed. The procedure is performed under local anesthesia.

The patient in Figure 2 had multiple episodes of contralateral transient attacks of hemiparesis. Endarterectomy was performed two years ago with complete relief of symptoms.

(B) Obstructions in the Vertebral Arteries

Most neurologists believe that occlusion of one vertebral artery is well tolerated provided the other vertebral artery is of normal size. Others feel that occlusion of one vertebral artery may result in the syndrome of the posterior inferior cerebellar artery.

Damage to the inferior surface of the cerebellum leads to homolateral loss of pain and temperature in the face and contralateral loss of these senses in the extremities and trunk, facial pain, vertigo, ataxia, vomiting, dysphagia, and Horner's syndrome. If both vertebral arteries become severely stenosed or occluded the basilar artery syndrome usually results. The characteristic features of this syndrome are bilateral pyramidal tract signs combined with unilateral or bilateral cranial nerve (III to XI) palsies. Other features may be added to this syndrome. Trans-subclavian visualization of the vertebral artery is extremely helpful in establishing the site or sites of obstruction in the vertebral-basilar system. Meyer and associates⁶ have recently described five principal sites of atherosclerotic changes in the vertebral-basilar system: (1) the proximal portion of the vertebral artery at its origin from the subclavian artery, (2) the cervical portion of the vertebral artery, commonly associated with exostoses and spur formation, (3) the intracranial portion of the vertebral arteries, (4) the basilar artery, and (5) the posterior cerebral artery. The most common site of involvement is the basilar artery and frequently several sites may be involved. Unfortunately, the majority of patients with vertebral-basilar artery involvement show lesions that are not amenable to surgical correction. On occasions one may find localized obstruction in the proximal portions of the vertebral arteries that are amenable to trans-subclavian endarterectomy.

The patient (Figure 3) was having intermittent transient attacks compatible with basilar artery insufficiency. Trans-subclavian endarterectomy was performed with relief of symptoms.

Summary

Patients with symptoms associated with cerebral vascular insufficiency may have segmental atherosclerotic obstructions in the extracranial portions of the major arteries that supply the brain. It may be

possible to restore a normal lumen to the involved artery or arteries and thereby relieve the patient's symptoms and neurologic deficit. An aggressive approach, including arteriography in many instances, to the problem of recurrent focal cerebral ischemic attacks and to strokes in general is essential in order to outline the best treatment program for each patient.

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Addendum

Selection of these patients for surgery is extremely difficult and as yet ill defined. The initial enthusiasm associated with any new surgical procedure is frequently found to be excessive. This was found to be true for stellate ganglion block in the treatment of cerebral artery thrombosis. The mere presence of a stenosing atherosclerotic plaque in the internal carotid artery or vertebral artery does not insure that removal of the plaque will benefit the patient. The improvement in these patients following removal of an atherosclerotic plaque may not be entirely related to the operative procedure as some of these patients improve spontaneously. The ability to tolerate obstruction in one or more of the four major arteries that supply the brain is dependent upon the development of collateral circulation. From a practical standpoint my experience has shown that little benefit is obtained by removing plaques from the vertebral arteries. As experience has accumulated the value of having these patients seen by a neurologist and an ophthalmologist has become increasingly apparent. I believe that while the present surgical procedures have a limited place in the management of patients with cerebral vascular insufficiency, further study is needed to determine the true indications and benefits.

HOSPITAL MEAL COSTS AVERAGE \$3.64 DAILY

THE COST OF PREPARING patient meals in the nation's hospitals averages \$3.64 per patient day, according to a report in *The Modern Hospital* magazine.

The professional journal said the cost of feeding patients is one of the largest hospital operating expenses.

Nationally the cost per patient day ranges from a low of \$2.11 in city, county, and state hospitals in the south and southwest to \$5.88 per patient day in hos-

pitals of 250-or-more beds in the western states.

About half of the kitchen cost goes for food and the remaining half for salaries and other costs.

The magazine also reports the survey found that 83.2 per cent of the hospitals replying said they employ a full-time dietitian, 8.4 per cent hired one on a part-time basis while 6.3 per cent did not employ a dietitian.

ASPIRATION TREATMENT OF PERITONSILLAR ABSCESS

*All the local signs of infection were gone in an average of six days,
which is comparable to the cases treated by incision.*

James T. King, M.D., *Atlanta*

I CAN REMEMBER WITH vividness my first experience with peritonsillar abscess. As a senior medical student while serving as an apprentice in the emergency room of our hospital, a young man was seen with peritonsillar infection. There was massive excruciatingly tender swelling in the throat as well as the upper cervical area, swallowing was extremely painful if not impossible. He was dehydrated, feverish, and trismic. The interne in charge incised the palate whereupon with little or no anesthesia. A nick was made in the mucous membrane of the supratonsillar area and a hemostat was inserted and spread thus tearing the palate open. At which instant, the patient cried out. This was followed by sobbing interspersed with spitting of blood, saliva, but alas no pus. Another plunge was advised, but the patient would not permit it. It was thought that the patient would be all right and was sent home. Two days later he was admitted to the hospital with deep neck infection and was to die from general sepsis. This was by no means an uncommon occurrence in the prepenicillin era.

Another memorable case came four years later and illustrated that all that is fluctuant around the tonsils is not abscess. I was then serving as senior resident in another hospital and a colored boy, about nine years old, having peritonsillar swelling, was referred in by a Negro physician with a diagnosis of abscess. That this condition is uncommon in a child, the patient was not acutely ill, had no sore throat or

cervical glandular reaction did not register on my "know it all" brain and I proceeded to drain his throat. With the first nick I met bright blood, and it was obvious that this was an aneurysm (false). A purse string suture was hurriedly put in place and the bleeding was controlled. Later a visiting surgeon operated to ligate the carotid artery, but unfortunately the child died from cerebral ischemia or blood loss. It was about this time that I learned some of the better known ENT teaching hospitals prohibited their residents from opening these abscesses and admitted them to wait for spontaneous rupture.

All this led me to seek another way of dealing with this condition. For the past 12 years I have used aspiration almost exclusively as the principle drainage treatment in peritonsillar abscess. And for the four years preceding the 12 (1945-1949), I used aspiration in a number of cases and in another group I employed incision and was thus able to compare the results of the two types of treatment.

Technic

First the throat is palpated for obvious reasons. An applicator dipped in adrenalin-cocaine mixture is pressed against the spot on the soft palate selected for aspiration. This not only causes some surface anesthesia, but also a local blanching, which helps when after a minute or two, 0.1 cc. of two per cent xylocaine is injected superficially into the spot. This may seem to be taking anesthesia to an extreme, but several of these patients had previous abscesses incised and were hurt enough to be quite grateful for anything that will lessen pain. Then, with an 18

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gauge spinal needle on a 10 cc. syringe, the anesthetized area is pierced. Usually the abscess pocket is surprisingly deep and when the wall is entered, there is a feel of having punctured a tightly stretched membrane. As much pus as possible is drawn into the syringe and I find that size needle not a bit too large since the pus is quite thick. The procedure is often repeated the next day.

Statistics

Now, for the inevitable statistics. These will cover, in general, only the 42 cases of unilateral peritonsillar infection treated by aspiration in the last five years. In three of these there was no pus and the procedure was needless. In one case the pus was so thick that it could not be evacuated, even though the largest available needle (15 gauge) was used. This case had to be treated by routine incision. In the remaining 38 an average of about two cc. of pus was obtained. Almost all were strikingly improved by the next day, perhaps even more so than those treated by incision. In no instance was there any worsening in the condition of any of these patients following aspiration. In 25 cases, aspiration was repeated 24 hours later and pus was found in 16, though only about 0.3 cc. of pus was average. In nine cases, aspiration was done again on the third day, but I have never found pus after the second aspiration. All the local signs of infection were gone in an average of six days, which is comparable to the cases treated by incision. All these patients received antibiotic treatment in one form

or another, usually daily penicillin-streptomycin injections. While this additional treatment may have checked the spread of infection, three cases seen earlier—those with negative aspiration—may have aborted the abscess since none formed. However, antibiotics did not otherwise seem to affect the course of the infection. In eight cases, one cc. of procaine penicillin (400,000 U) was injected into the abscess cavity following withdrawal of the pus, but apparently this had no effect either way.

As to comparative pain between aspiration and incision, there were nine patients who had previous abscesses incised and subsequently had another treated by aspiration. These were queried as to which procedure was less painful. Six, all good patients, voted for my method. Two others must have been hurt in more ways than one since they did not reply to my inquiries or my statements. The ninth posed possibly the biggest disadvantage of the technic. He said there had been such anguish with previous abscesses that when he came to me he had already made up his mind to have his tonsils out, but when he found he could have it treated so painlessly, he decided to forego surgery after all.

Summary

Aspiration has been used in the drainage of peritonsillar abscess for the past 15 years. It has proven safe, effective, and relatively painless.

340 Boulevard, N.E.

HEALTH CARE FOR AGED UNDER SOCIAL SECURITY

ELECTION OF SEN. JOHN F. KENNEDY as President made it probable that the issue of providing health care for the aged under Social Security again will be raised in Congress next year.

Kennedy will go into the White House pledged "to the immediate enactment of a program of medical care for the aged through Social Security." His intentions present a serious challenge to the nation's physicians who have vigorously opposed use of the Social Security system to provide health care for the aged.

Kennedy's program would provide what he described as a "life policy of paid-up medical insurance" for older persons. "It would provide them hospital benefits, nursing home benefits, and x-rays and laboratory tests on an out-patient basis," he said in his campaign for the Presidency.

He said the Kerr-Mills legislation enacted into law last summer is inadequate. The medical profession supports this federal-state program to provide health care for needy and near-needy aged persons. In approving the Kerr-Mills program, Congress rejected the Social Security approach espoused by Kennedy and union labor leaders.

Kennedy's medical program also included: federal grants for construction, expansion, and modernization of medical, dental, and public health schools; federal loans and scholarships for medical students; federal grants for renovating older hospitals; increased federal financial support for medical research, including basic research, and expansion of federal programs for rehabilitation of handicapped or disabled persons.

DIABETES AND THE XANTHOMAS

Because of their different prognostic implications, it is essential that an accurate diagnosis of these skin lesions be made.

Herbert S. Alden, M.D., Atlanta

SHAKESPEARE IN THE PLAY, *King Henry IV*, has one of his characters, Sir John Falstaff, who is a fat and gouty roue, fearful of the pox, ask his page, "And what does the doctor say about my water?" The page replies quite flatly, "The doctor says that as far as the water is concerned it is strong and healthy, but as for he who owns it, he has more diseases than he knows of."

We have come a long way from this simple uroscopy examination which was done by Falstaff's physician, but our prognosis for the patient hasn't changed too much, since sometimes we come to the same conclusion that the diabetic "has more diseases than he knows of." Most prominent among these diseases of the skin, associated with diabetes, are the xanthomas. The appearance of these yellow tumors on the skin, often having all of the phases of the xanthic colors of the leaves in our fall season of the year, from light brown to pink to deep yellow, are usually quite striking, and obvious both to the patient and the physician, and once seen will not be quickly forgotten.

Lack of space and time does not make it possible to discuss in detail all the biological and biochemical phases of the xanthomas and the related lipid and cholesterolemic diseases or of some of the fat degenerative conditions which involve the skin. Let me, therefore, limit these observations to three types which should awaken your clinical interest. In this respect, I should like to call your attention to an article in the *Southern Medical Journal* of April, 1960, by Dr. Walter Lever of Boston in which he discusses the relation of the hyperlipemias and the hypercholesteremias. It is well worth careful reading.

The three conditions I should like to discuss with you are: (1) the *eruptive xanthoma*,¹ associated

with hyperlipemia; (2) the *essential familial xanthomas*² of which xanthelasma and the tuberous xanthoma are the most frequent, and (3) the degenerative fat necrosis,³ known as *necrobiosis lipoidica diabetorum*.

Not only do these three types of xanthoma have different clinical appearances, but they also carry with them different types of prognosis for the patient's continued health and welfare, and, as such, it would be important, therefore for a clinical differential diagnosis to be made.

Let me begin by reading you a portion of the original case report of xanthoma associated with diabetes (the eruptive type) that was made by Dr. Thomas Addison, one of the most acute clinical observers of disease of the 19th Century. He writes, "On the 18th of August, 1848, a patient was admitted into the hospital for diabetes. He was a man, age 27, who stated that about six months before he began to pass an unusual quantity of water, feeling at the same time weak and feverish with dry, harsh skin. On admission he presented the ordinary symptoms of diabetes. He voided four pints and a half of urine daily. On the 25th of January of the following year the quantity of urine was seven pints and a half daily. At this time an eruption somewhat suddenly appeared on his arms, at first apparently of a lichenous character (papular). In the course of ten days observation it had extended over the arms, legs, and trunk, both anteriorly and posteriorly, and also over the face and into the hair. It consisted of scattered tubercles of various sizes, some being as large as a small pea, together with shining colorless papules. The most numerous on the outside and back of the forearm, and especially about the elbows and knees where they were confluent. Some looked as if they were beginning to separate, but when incised with a lancet they were found to consist of

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firm tissue which on pressure gave out no fluid save blood. (This is a good clinical test.) They were of a yellowish color, mottled, with deepish rose tint, and with small capillary veins here and there ramifying over them." This clinical description is quite typical of the eruptive xanthoma diabeticorum, as is seen today. Not infrequently, diagnosis can be suspected from the history and physical examination alone, as in Addison's case, but had Dr. Addison taken a specimen of the blood, and allowed it to clot, the excessive lipemia in the serum in the form of a milky fluid would have been immediately noted, and an examination of the urine would have revealed sugar. (This form of lipemia of severe diabetics results apparently from insufficient carbohydrate utilization; fat is mobilized from the fat depots, and "transport" hyperlipemia results.)

Because treatment of diabetics has vastly improved in recent times, hyperlipemia and eruptive xanthoma have become fairly rare. While this type of xanthoma almost invariably is associated with a hyperlipemia, it is not necessarily associated with diabetes, but it is associated frequently enough to make it significant. Here, attention to the care of his diabetes and reduction of fat intake will result in relief, but the situation can very quickly be reversed, particularly, by the intake of large quantities of alcohol.

Disseminated Xanthoma

One must distinguish clinically and historically this type of diabetic xanthoma from the *disseminated xanthoma* which has very much the same clinical picture, excepting that the onset is very gradual; it usually consists of very small, more brown than yellow papules and plaques, appearing particularly on the flexor surface in the axillary folds and groin. This disease is very rare, and very little is known about it except that serum levels of the cholesterol, the total lipids, and the blood sugar are always within normal limits, and, so far as I know, dietary therapy has not been of any help. Because of the rarity of occurrence of these cases it has not been properly evaluated. It is probably related to the aberrant and transient type of xanthomas that occur in childhood, and also may be related to the urticaria pigmentosa which is the result of mast cell infiltration.

The Essential Familial Xanthomas

While this disturbance of lipid metabolism is only associated with diabetes, occasionally, it is important to distinguish these types of xanthoma from the eruptive xanthoma I just described, because of the potentially serious prognosis of the familial xanthomatosis. (In this respect I should

like to call your attention to an article in the *Journal of the Medical Association of Georgia* of March 1960 by Dr. Gerald R. Cooper and others, titled, "Atherogenesis and Its Relation to Diabetes.")

In this category of essential familial xanthomas, there are two types: (1) the xanthoma of the eyelids, or xanthelasma, and (2) and the tuberous xanthomas. The former are more frequently seen, while the latter carry with them a much more serious prognosis.

Careful genetic studies have demonstrated that the familial hypercholesterolemia and xanthoma is an inherited abnormality of the lipid metabolism. About half of the patients eventually develop coronary atherosclerosis or angina pectoris and peripheral vascular diseases are common in this group (every case of coronary occlusion in children and adolescents has been associated with xanthoma tuberosum). The atheroma that occur in the vascular system are very similar in the histopathological appearance as to those seen on the skin.

Xanthoma of the Eyelids

However, of the two types, the *xanthoma palpebarum*, or xanthoma of the lid is less likely to have a serious prognosis, since only 40 per cent of these patients show an elevation of the serum cholesterol. While many of the patients with tuberous xanthoma and hypercholesterolemia have xanthoma of the eyelids, it is common for the *xanthelasma* to appear independent of any general changes in the lipid metabolism. The xanthoma of the eyelids, when present alone, appear in the fourth to sixth decades and persist throughout life. They appear as soft chamois, yellowish brown, velvety lesions in the eyelids which slowly enlarge peripherally to the slightly elevated plaques. They rarely become large enough to obstruct vision, but as a cosmetic defect they become a source of concern, particularly to the female. Because nearly one half of these folk have some lipid metabolic disease, I believe each should be investigated for hypercholesterolemia and/or diabetes, and when xanthoma is present the patient should be warned, but not frightened about the possibilities of vascular disease later on in life. These tumors can be readily assuaged by the careful use of trichloroacetic acid locally, or by surgical removal, but recurrence is likely and probably inevitable. The *tuberous xanthomas* appear as hard dermal areas on the extensor surface of the arms and over the tendons, particularly the achilles tendon. Often firm, brown to yellow nodules and papules tend to occur in the other areas, particularly the large joints in the buttocks and in areas of pressure. Injury must be a predisposing cause of this type of eruption. The

color of these isolated lesions can be often elicited by pressure of a glass slide. These patients will usually have a very high blood cholesterol, and the frequency of heart disease is high. In general, there seems to be little value in the low fat, or low cholesterol diets in these patients, although this is doubted by some, but I know of no treatment either locally or internally that affects the size of these nodules. Recently, Dr. Roy Kile of Cincinnati has reported the lowering of the cholesterol and the softening of some of these tumors with the use of levo-rotary thyroxin, but in the one patient, in which I have used it, there was no change in the cholesterol in three months, but some softening of the nodules has been noted.

Necrobiosis Lipoidica Diabeticorum

While this more or less localized collagen degeneration is not, despite the qualifying term "lipoidica," a disease of either the lipid or cholesterol metabolism of the body, it is one of the "yellowing" skin diseases, and is associated with diabetes about 80 per cent of the time. Its clinical characteristics are such that it should be readily recognized, since it occurs almost exclusively on the skin of the lower legs, and most frequently over the shins. It is predominantly a disease of the female. It may occur at any age, but more often in the middle decades, and sometimes follows history of trauma or injury.

It is a highly distinctive skin eruption consisting of oval, firm, yellowish plaques with two zones of color—bright yellow to buff surrounded by bluish violet or wine red border. Often this border is elevated to the palpating finger, and extends peripherally. As extension occurs, central atrophy with thin, glossy skin and telangiectasis are present, sometime resulting in an ulcer. If traumatized or incised, necrosis and ulceration are slow to heal. The histopathology is clear and distinctive. Of four individuals recently seen, two had extensive and prolonged eruptions of their legs, one of which followed an application of a spica cast. Improvement with scar has occurred with the use of small repetitious doses of steroids by mouth. One has improved, but recurred with the use of Depo-Medrol®, and since the other patient had diabetes; the cortisones could not be used. Control of the diabetes, as a rule, does not affect the localized necrobiosis. Before steroid treatment, one must be careful to eliminate the possibility of diabetes.

To distinguish between the type of xanthic tumors of the skin, it requires: (1) a good clinical examination of the patient, undressed; (2) a suspecting mind; (3) a good clinical history, and (4) a visual examination of the clotted blood, and a cholesterol and glucose examination of the blood, if possible, and always a urinalysis. The clinical and pathological characteristics of these xanthomas are clear and well defined, and therefore, biopsy of one of the smaller isolated tumors should always be diagnostic.

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INFLUENZA VACCINATION FOR PERSONS WITH HEART DISEASE

ROUTINE VACCINATION AGAINST influenza for persons with heart and blood vessel disease has been recommended by the American Heart Association and the National Heart Institute of the U. S. Public Health Service.

In releasing a statement to this effect, Dr. A. Carlton Ernstene, immediate past president of the AHA, and Dr. James Watt, NHI director, said:

"Evidence of the past three years has abundantly confirmed that the dangers of influenza are much greater for patients with heart or lung disease than for others. The risk is particularly high for those with lung congestion due to heart disease."

Excerpts from the statement follow:

"The epidemics of influenza which occurred in the fall of 1957, the spring of 1958, and the first quarter of 1960 have again emphasized the fact that individuals with cardiovascular or pulmonary disease are more susceptible to the hazards of influenza than is the gen-

eral population. The increased risk is shown both by more severe illness and by higher fatality rates among patients with these diseases.

"Evaluation studies with influenza virus vaccine have shown that its use is of definite value in preventing influenza. In adults, side reactions have been extremely few and use of the vaccine is contraindicated only in those patients who are allergic to components of the vaccine.

"The Public Health Service Advisory Committee on Influenza Research has strongly recommended that those persons at high risk of death from influenza obtain immunization as a protective measure.

"The American Heart Association and the National Heart Institute wish, therefore, to bring these facts to the attention of all physicians. In addition, it is urged that persons with cardiovascular disease consult their physicians as to the advisability of obtaining routine influenzal vaccinations."

RESPONSIBILITY TO THE INJURED

George J. Curry, M.D., *Flint, Michigan*

MUCH HAS BEEN SAID about this subject. Most everyone is aware of its seriousness. The problem presents a tremendous challenge to the entire medical profession. A few pertinent facts follow and special reference will be made about the immediate care and transportation of the injured:

(1) Trauma is the greatest cause of death in children from one to 14 years of age.

(2) One per cent of all accidental injuries (10,000,000) result in death.

(3) About 270 are killed daily from all causes.

(4) Traffic accidents kill 100 and injure about 350 daily; four and 14, respectively, every hour.

(5) The yearly economic loss from accidents is about 10 billion dollars—26,500,000 daily. The first amount was three times the national debt of the United States shortly after the Civil War.

(6) The medical costs for injuries is about 700 million dollars yearly—two million daily; 84,000 hourly; 1,400 every minute, and 23 every second.

(7) The modern automobile improperly driven has become the most dangerous weapon ever placed in the hands of a civilian. The Korean War killed an average of 8,534 boys every year. Four times as

many were killed in one year on our highways.

(8) Speed is the cause of more than 50 per cent of all fatalities in automobile accidents. Driving 50 miles an hour at night is as fast as you can go safely without over-driving your headlights. Do not talk and look at the other fellow while driving.

The Sixth Columnist

The irresponsible driver should have a name which would properly tag him. My nomination would be "The Sixth Columnist." Why? Because he causes more economic and social loss each year than an invading army; when he becomes a macadam cowboy, he does so deliberately. Seeking a cheap thrill at the expense of life and property; he is a bigger menace than the drunken driver because he usually has the use of his senses which a drunken driver loses in his progress to drunkenness, and he is your enemy, my enemy, the enemy of all of us and sometimes the enemy of unborn children. You may choose whatever name you will; I will stick with "The Sixth Columnist."

Transportation of the Injured

In a five year study, 1949 to 1953, 62 cities with a population of 30 million and ranging in size from 2,000 to eight million, was made to determine the

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RESPONSIBILITY TO INJURED / Curry

quality of transportation. About one in four was poorly transported. Transportation was better in smaller towns. An ambulance does not need to speed. The patient deserves a safe ride to the hospital.

Summary

Responsibility to the injured begins with:

A. Prevention

1. A well organized traffic safety program.
2. Driver education.
3. Improvement in highway construction.
4. More stringent requirements for driver licensure.
5. Safety in automobile design; example: doors, panels, steering apparatus, seat belts, etc.

continues with:

B. Education and certification of the ambulance attendant to insure better *immediate care and transportation to the hospital.*

C. Efficient and expeditious organization of the

emergency receiving departments of hospitals; around the clock care by house staffs, interns, and residents under staff section supervision and instruction; experienced nursing supervision and adequate help, and adequate facilities for thorough evaluation of the injured person (x-ray, splinting of fractures, etc.).

D. Transportation within the hospital—efficient speedy (Limbach Single Stretcher System) and elimination of unnecessary handling.

E. Good staff organization consisting of qualified and experienced surgeons to render proper and expeditious care, assisted by specialty consultants; *continuous appraisal of work done*, by regular section conferences and rounds, clinical investigation assignments, and *critical analysis*.

F. Long term follow-up care at regular intervals.

G. Rehabilitation.

and ends:

H. *When maximum result has been obtained anatomically, functionally, and economically.*

401-3 Genesee Bank Building

UNDERSTANDING AND COOPERATION NEEDED TO ACHIEVE VOLUNTARY HEALTH INSURANCE

"IT IS ABSOLUTELY ESSENTIAL that the insurance industry achieve an atmosphere of understanding and cooperation with the providers of medical care" in order to develop and maintain a program of voluntary health insurance that will give the public the best of medical care at a reasonable cost, Raymond F. Killion, Second Vice President of the Metropolitan Life Insurance Company, said November 10.

Mr. Killion, Chairman-Elect of the Health Insurance Council, spoke at an eastern regional meeting of the HIC at Boston's Sheraton Plaza Hotel.

Understanding and cooperation can be brought about, said Mr. Killion, "only through repeated contacts—face to face discussion—amongst the people concerned." He said misunderstandings could grow and "become a major irritant, but through personal discussion can be readily eliminated."

The HIC embarked on its program of state committees in 1957 to strive for understanding with the providers of medical care, he said, and in three years the HIC has established committees in 49 states with more than 500 insurance company representatives in active participation.

He said much has been accomplished by the state

committee program "but much remains to be done."

Mr. Killion said one problem facing the insurance business was presented by the formation of a national Blue Cross organization.

A particular purpose of the new organization, Mr. Killion declared, is to "step up its competitive position in providing hospitalization insurance for employees of national business organizations." He said the insurance business "is of course prepared to cope with fair competition which is, after all, a dominant characteristic within our industry."

In the area of reimbursement of hospitals, he said, it was the position of the insurance business that any reimbursement formula should be equitable and "should not result in the subsidizing of one group of hospital patients by another."

He added: "In our discussions with hospital representatives, we should be mindful of the tremendous contribution made by the Blue Cross organization in the financing of hospital care. They have our respect. On the other hand, it should be strongly emphasized that the insurance industry has also made a tremendous contribution in the field of hospital expense insurance and we ask for no more than just recognition."

1961 CALENDAR OF MEETINGS

State

- Feb. 13-17—Basic Science Lecture sponsored by the Sisters of Mercy and the Medical Staff of St. Joseph's Infirmary, St. Joseph's Infirmary, Atlanta.
- Feb. 19-22—Atlanta Graduate Medical Assembly, Biltmore Hotel, Atlanta.
- Feb. 23—Fourth Southwest Georgia Seminar, Municipal Auditorium, Albany.
- Feb. 28-Mar. 2—"Management of Your Patient with Vascular Disease," Medical College of Georgia, Augusta.
- Mar. 2-4—Georgia Society of Ophthalmology and Otolaryngology, General Oglethorpe Hotel, Wilmington Island, Savannah.
- Mar. 10-11—"The Physical Examination of the Cardiovascular System," Grady Memorial Hospital Auditorium, Atlanta.
- Mar. 20-24—Basic Science Lecture sponsored by the Sisters of Mercy and the Medical Staff of St. Joseph's Infirmary, St. Joseph's Infirmary, Atlanta.
- Mar. 21-23—"Gynecology in General Practice," Medical College of Georgia, Augusta.
- May 7-10—Annual Session, Medical Association of Georgia, Atlanta Biltmore Hotel, Atlanta.**
- June 11-14—Georgia Pharmaceutical Association, Biltmore Hotel, Atlanta.

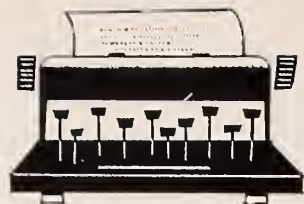
Regional

- Jan. 26-28—Eighth Annual Seminar on Cardiovascular Diseases, George Washington Hotel, Jacksonville, Florida.
- Feb. 14-17—Mid South P.G. Medical Assembly, Hotel Peabody, Memphis, Tennessee.
- Mar. 6-9—Southeastern Surgical Congress, Deauville Hotel, Miami Beach, Florida.
- Mar. 6-9—New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, Louisiana.
- Mar. 10-11—Southeastern Chapter of the Society of Nuclear Medicine, The Academy of Medicine, Atlanta, Georgia.
- Mar. 20-22—Dallas Southern Clinical Society, Statler-Hilton, Dallas, Texas.
- Apr. 9-12—Tennessee State Medical Association, Read House Hotel, Chattanooga, Tennessee.
- Apr. 22-25—Texas Medical Association, Galvez and Buccaneer Hotels, Galveston, Texas.
- Sept. 25-26—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tennessee.
- Nov. 6-9—Southern Medical Association, Municipal Auditorium, Dallas, Texas.

National

- Feb. 4-7—Congress on Medical Education and Licensure, Palmer House, Chicago, Illinois.
- Feb. 6-8—American Academy of Allergy, Statler-Hilton Hotel, Washington, D. C.
- Feb. 8-11—American College of Radiology, Drake Hotel, Chicago, Illinois.
- Feb. 9-15—Second Allergy Conference, Bahamas Conferences, Nassau, Bahamas.
- Feb. 20-24—Postgraduate Course in Selected Topics in Internal Medicine, American College of Physicians,

- University of Oklahoma School of Medicine and University Hospitals, Oklahoma City, Oklahoma.
- Mar. 6-10—Postgraduate Course in Recent Advances in Cardiovascular Disease, The Mount Sinai Hospital, New York, New York.
- Mar. 9-11—Eastern Conference of Radiology, Lord Baltimore Hotel, Baltimore, Maryland.
- Mar. 12-17—American College of Allergists Graduate Instructional Course and Seventeenth Annual Congress, Statler-Hilton, Dallas, Texas.
- Mar. 13-17—Postgraduate Course in Internal Medicine: Selected Topics, McGill University Department of Medicine, Montreal, Canada.
- Mar. 13-25—Postgraduate Course in Laryngology and Bronchoesophagology, Department of Otolaryngology, University of Illinois College of Medicine, Chicago, Illinois.
- Mar. 20-24—Postgraduate Course in Medical Technology, University of Colorado Medical Center, Denver, Colorado.
- Mar. 20-24—American Surgical Association, Boca Raton Hotel, Boca Raton, Florida.
- Mar. 20-24—Postgraduate Course in Advanced Clinical Electrocardiography, University of Tennessee College of Medicine, Memphis, Tennessee.
- Mar. 23-25—Postgraduate Course in Endocrinology and Metabolism, University of Virginia Medical Center, Charlottesville, Virginia.
- Apr. 3-8—The Gill Memorial Eye, Ear and Throat Hospital, 34th Annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties, Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Virginia.
- Apr. 3-15—Eleventh Medical Conference, Bahamas Conferences, Nassau, Bahamas.
- Apr. 6-8—Fourteenth Annual Meeting, West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Virginia.
- Apr. 10-12—American Academy of Pediatrics, Sheraton-Park Hotel, Washington, D. C.
- Apr. 12-15—Postgraduate Course in Problems of Growth and Aging, The Lankenau Hospital, Overbrook, Philadelphia, Pennsylvania.
- Apr. 13-20—American Academy of General Practice, Miami Beach, Florida.
- Apr. 30-May 6—Conference on Internal Medicine, Bahamas Conferences, Nassau, Bahamas.
- May 8-12—American College of Physicians, Americana Hotel, Miami Beach, Florida.
- May 15-19—Postgraduate Course in Gastroenterology, University of Pennsylvania Graduate School of Medicine, Philadelphia, Pennsylvania.
- May 16-20—American College of Cardiology, Inc., Biltmore Hotel, New York, New York.
- June 19-23—Postgraduate Course in Current Aspects of Internal Medicine, State University of Iowa College of Medicine, Iowa City, Iowa.
- June 22-26—American College of Chest Physicians, Hotel Commodore, New York, New York.
- June 26-30—American Medical Association, Annual Meeting, New York, New York.**
- Oct. 15-20—Fourth International Congress of Allergology, the Hotel Commodore, New York, New York.



editorials

The Lines Are Drawn Again

DESPITE THE FACT THAT Congress enacted a broad new program for health care of the needy and near-needy aged last year, President Kennedy and the Democratic leaders of Congress will push for a compulsory program tied to Social Security during the 1961 session.

Proponents of Forand-type legislation have tried to belittle the Kerr-Mills Bill as "inadequate" and a "stop-gap measure." Actually, the Kerr-Mills Bill will require hundreds of millions of dollars and will provide care for *all* persons over 65 who *need* help.

Before Georgia and the other states will hardly have had an opportunity to participate in this new program, the Democratic administration will be pushing for a national compulsory program to include all persons over 65 whether they need it or not. Decisions as to eligibility, benefits, fees, and all other matters will be made in Washington rather than at the state and local level as under the Kerr-Mills Bill.

All of these factors were made abundantly clear during the recent 14th Clinical Meeting of the Ameri-

can Medical Association in Washington, D. C. It was most appropriate that the meeting was held in Washington, for many of the statements by the officers of the Association and by the House of Delegates seemed directed as much to the new administration as to the physicians.

These statements reaffirmed medicine's opposition to social security medicine and urged all physicians to support state officials and provide leadership in implementing the Kerr-Mills Bill. The statements were clear and left no doubt as to where medicine stands.

As the 1961 session of Congress progresses, we wish to urge every physician in Georgia to keep himself, the members of his community, and his Congressman informed on this vital issue. The influence of one man may make the difference between the free practice of medicine and high standards on the one hand, and national compulsory health insurance and uniformly lower standards on the other.

Priority Projects for 1961

THE MEDICAL ASSOCIATION HAS undertaken a number of ambitious projects for 1961. A preview of the enthusiasm manifested by physicians in these programs was seen in Atlanta recently at the MAG

Annual County Society Officers Conference. This two-day program was well attended by county society officers from over the state.

Superimposed on our cover illustration for this

month will be seen a tabulation of some major areas of activity of the Association for 1961. Because of the importance of these activities, it is felt that further amplification is in order.

Health Care of Aging—The medical profession, having given its full support to the Kerr-Mills Bill (H.R. 12580), now must assume responsibility for the implementation of this measure—through full cooperation, participation, and possibly some phase of regulatory administration. Proponents of Forand-type legislation are indicting this measure as “inadequate” and are predicting its failure. It behooves the profession to prove that medical assistance for the aged can be based on the philosophy of “need and not right,” of “local control and administration,” and of the “free choice of physician, thereby preserving the physician-patient relationship.”

Doctor-Patient Relationship and Cost of Medical Care—Companion to the science of medicine is the “art of Medicine” which is based on the doctor-patient relationship. This “face-to-face” contact with the patient during diagnosis and treatment can become the basis of more favorable public attitudes toward the profession. Certainly the questions of diagnosis, treatment, and the costs of medical care can best be handled during the personal discussions between the physician and patient. Those who favor socialized medicine would destroy this relationship—yet, it is well to remember that “third party medicine” can only succeed when the physician repudiates his responsibility of maintaining rapport with each of his patients. The profession must re-emphasize the ideal of preserving genuine doctor-patient communication.

Physician Supply and Distribution—Georgia has gained about 100 additional physicians per year during the past four years. The Association has an active Physicians Placement Bureau at the Headquarters Office. This activity should be improved beyond the exchange of doctor-seeking-location and location-seeking-doctor questionnaires with physician participation. The Association should also establish an even closer liaison with the State Medical Education Board to insure the best placement of the “scholarship M.D.’s.”

To maintain and insure increased medical school applicants, the MAG should consider an all out program of medical and paramedical recruitment. This project could be carried out by the 70 component county medical societies stimulating young people at county fairs, career day programs in high schools, etc. AMA has prepared an excellent “how to do it” kit for this purpose.

Mental Illness—The MAG has made great strides in improving institutional care of the mentally ill and the treatment of the mentally ill through its

liaison with Governor S. Ernest Vandiver. To maintain this interest and guidance is most important and MAG should continue its leadership in this field and keep the public informed at all times of this continuing activity.

National Debate Topic: “Compulsory Health Insurance”—The National Intercollegiate Debate topic for 1960-61 is: “Resolved: That the United States Should Adopt A System of Compulsory Health Insurance.” College and high school debaters are seeking material in their community so that they may participate in this activity. The AMA has prepared a kit of materials of special information on this subject. It behooves MAG to see that these kits are distributed to each component county medical society so that they may be available for use by debaters in each community. These kits will assist the youth of our nation in conducting a fair and unbiased investigation of the debate topic so that they may be prepared to know all the data relative to this issue.

MAG Membership Relations—The Association should continue its program of maintaining strong county medical society leadership providing original jurisdiction at the county society level. As an MAG chain is dependent on each of its links; so the success of MAG activity is dependent on its component county medical societies. Councilors from each of the councilor districts and large medical societies must stimulate the county societies within their districts to really assume medical leadership of the community. And MAG should further consider the importance of fellowship activities for its membership because this will maintain better “doctor-to-doctor” relationships. In short, emphasis should be placed on improved relationships *within* the profession.

MAG Relationships with other Organizations—Because Health Care of the public is such a complex field with other participants besides physicians, it would aid the profession to improve its liaison with other organizations such as the Georgia Hospital Assn., Georgia Dental Assn., Georgia Association of Nursing Homes, Georgia Pharmaceutical Assn., etc. The Association also should become increasingly active in cooperation with Chambers of Commerce, farm groups, business organizations, etc. In short, the MAG should emphasize working with “outside” groups so that the aims of the profession can be better understood—and take fuller advantage of the opportunity to make more friends for medicine.

State and National Legislation—The primary purpose of the MAG is “to promote the science and the art of medicine and the betterment of public health.” As the “Guardian of Georgia’s Health,” the MAG must maintain and improve its legislative liaison at

the county, state, and national levels. It is the Association's duty, as the authority in the field of health care, to provide legislators with data on good medical care when proposed health care legislation is pending. The Association should take an active part in

such matters as they affect the health of the citizens of Georgia.

It is hoped that each member of the Medical Association of Georgia will investigate these important programs through his county society officers. If each member could identify himself with at least one of these projects during the coming year, the success of our projected program will be assured.

Group Therapy for Obesity

TODAY THE EMPHASIS in both the lay and medical press is on the disadvantages of obesity and on attempts to correct it. This viewpoint is somewhat new, for until the early part of this century both physicians and laymen were relatively unconcerned about obesity, the effects it has on the physiology of the body, and the complicating diseases which result from it. The first serious paper on obesity was written by a layman, William Banting, in 1862, "Letters on Corpulence Addressed to the Public." His doctor, William Harvey, a Fellow of the Royal College of Surgeons, was the first physician to present a rational diet for the treatment of obesity.

From our ancestral cave dwelling days down through the Middle Ages, and even through the Victorian Era, obesity was socially acceptable. With the advent of the Flapper Age and the emphasis on flat chests and boyish hips, there arose a feeling of disgust concerning obesity. The fat individual became the butt of joke and story. Since that time, the literature has been filled with various ideas concerning the ill effects of obesity on the individual and many forms of therapy have been suggested.

The definition of obesity is not a settled point, but it is usually said to exist when an individual's weight is 20 per cent greater than the average weight for his respective height and age as established in medico-actuariaral tables of 1912. One in five persons over 30 years of age is obese under this definition. Actually these prepared tables are far from "ideal" because they are not adjusted for particular body builds nor are they weighted for ethnic, socioeconomic, or ecologic variants. The simplest defini-

tion is probably that obesity is the accumulation of excess adipose tissue.

There have been many explanations for the cause of obesity, but obviously it cannot occur unless caloric intake exceeds caloric expenditure due to physical activity. Modifying factors are such things as heredity; endocrine dysfunction, as seen in hypothyroidism and Cushing's disease; hypothalamic disturbances; the social and economic importances attached to food; psychological stresses and frustrations, and emotional problems such as the desire to destroy oneself or oral gratification as a substitute for sexual satisfaction. The diversity of these explanations leads one to doubt their reliability.

With the advent of the flapper silhouette and advertisements of "Reach for a Lucky Instead of a Sweet" and "I'd Walk a Mile for a Camel," reducing diets became a fad and the problem of obesity had to be faced up to by physicians in general. Since that time the treatment has gone from one extreme to another. Various methods have been suggested: (1) bulk laxatives to fill the stomach and dull the appetite, (2) frequent small feedings of low caloric value, (3) modification of the appetite by the use of anorectic drugs, (4) psychological techniques, (5) mechanical reducing devices, and (6) the use of frightening medical statistics to show the relationship between arteriosclerosis, diabetes, heart disease, and obesity.

Unfortunately, human weakness makes the low caloric diet plan, although ideal in theory, work badly in practice. It is my belief that the newer concepts of individual and group therapy are two of the most practical methods of dealing with the greatest number of obese individuals in a practical

This editorial was written by Dr. Fitzpatrick while he was a Resident in the Department of Medicine, Medical College of Georgia, Augusta, Georgia.

manner. By stimulating in a positive way the patient's pride in himself and in encouraging competition between himself and others with the same problem, psychotherapy has a definite place in the handling of the obese individual.

The variety of drugs that have become available rather obviously illustrates the failure of the pharmacological approach. Many individuals cannot afford the drugs or are unwilling to put up with the nuisance of taking them. The primary factor for successful weight reduction is motivation. Motivation plus a modification of the normal diet seems to be the more ideal therapy for the obese. Group approach is the newest method in dealing with this problem. In group therapy there is a sense of togetherness among the people who share a similar problem. In many communities it is possible for graduate registered nurses, psychologists, and sociologists to carry out these programs on a community level. Another big factor in group therapy is the sense of competitiveness aroused amongst those with a common

problem. This factor works especially well among women.

Psychotherapy on an individual basis is also used in several forms. Good patient-physician relationship with a sympathetic understanding on the part of the physician is obviously helpful. Another new method of individual therapy is hypnosis. As reported by Winkelstein in the *New York State Medical Journal* in May, 1959, it has been given some definitely encouraging results. There are not enough trained psychiatrists and psychologists to handle the vast number of obese individuals on an individual basis, and, therefore, I feel that group psychotherapy will, in the near future, have a very definite place in the treatment of obesity. Physicians should be the leaders in organizing and stimulating qualified people on the community level to conduct such classes.

*Paul E. Fitzpatrick, M.D.
Department of Medicine
Medical College of Georgia, Augusta*

MEDICAL HISTORY OF WAR OFFERED

MANY OF THE MEDICAL lessons learned during World War I had to be relearned under fire during World War II because of paucity of distribution of the World War I medical history.

Lieutenant General Leonard D. Heaton, The Army Surgeon General, in an endeavor to prevent this costly relearning process, in the unhappy event of another war, has directed the preparation, publication, and distribution of the "History of the Medical Department, United States Army, in World War II." General Heaton is particularly anxious that information of the existence and availability of this History be circulated widely among the profession, both military and civilian.

Of the 48 volumes programmed for the series, 15 have been published and can be purchased at modest cost from The Superintendent of Documents, Government Printing Office, Washington 25, D. C. The set of 15 volumes may be purchased for \$66.50 or individual volumes can be obtained at remarkably low prices. Commanding officers of medical units may requisition copies for their Medical Units libraries by submitting DA Form 17 directly to The Historical Unit, U. S. Army Medical Service, Washington 12, D. C., ATTN: Promotion Branch.

Volumes now available are:

"General Surgery"—Edited by Michael E. DeBakey, M.D.

"Neurosurgery," Volume (Head Injuries) — Edited

by F. Glen Spurling, M.D. and Barnes Woodhall, M.D.

"Neurosurgery," Volume II (Spinal Cord and Peripheral Nerve Injuries)—Edited by R. Glen Spurling, M.D. and Barnes Woodhall, M.D.

"Hand Surgery"—Edited by Sterling Bunnell, M.D.

"Ophthalmology and Otolaryngology"—Edited by M. Elliott Randolph, M.D. and Norton Canfield, M.D.

"Orthopedic Surgery, European Theater of Operations"—Edited by Mather Cleveland, M.D.

"Orthopedic Surgery, Mediterranean Theater of Operations"—By Oscar P. Hampton, M.D.

"Physiologic Effects of Wounds"—Edited by Fred W. Rankin, M.D. and Michael E. DeBakey, M.D.

"Vascular Surgery"—Edited by Daniel C. Elkin, M.D. and Michael E. DeBakey, M.D.

"Cold Injury, Ground Type"—By Tom F. Wayne and Michael E. DeBakey, M.D.

"Dental Service"—George F. Jeffcott, D.M.D.

"Environmental Hygiene"—By James Stevens Simmons, M.D. and others.

"Personal Health Measures and Immunization"—By John E. Gordon, M.D., Tom F. Wayne, M.D. and others.

"Communicable Diseases," Volume IV—By John E. Gordon, M.D., Joseph Stokes, M.D. and others.

"Hospitalization and Evacuation, Zone of Interior"—By Clarence McKittrick Smith.



current clinical concepts

Good Medical Educational Program

A MAJOR CHALLENGE today is to point out to the community at large, and responsible citizens in particular, that a good medical educational program in a hospital creates good patient care.

Second Annual Conference on Graduate Medical Education, University of Pennsylvania, December 1-2, 1960.

Liver Cancer and Cirrhosis in Africa and the U.S.A.

THE RATIO OF CIRRHOSIS to cancer of the liver is 20 to one in the United States, whereas in many places in Africa the two diseases occur with equal frequency.

Cancer 13, (Nov.-Dec.) 1960.

Dilutinal Hypervolemia

TRANSURETHRAL RESECTION of the prostate gland is associated with dilutinal hypervolemia which under general or regional anesthesia is reflected in arterial hypertension, slowing of the pulse, and restlessness. The conscious patient also experiences nausea and disorientation.

Marx, Gertie F.; Koenig, James W., and Orkin, Louis R.: Dilutinal Hypervolemia During Transurethral Resection of the Prostate, J.A.M.A. 174, Dec. 3, 1960.

Surgical Anatomy of the Inguinal Region

EVERY PHYSICIAN WHO performs inguinal surgery will find this review helps to eliminate the confusion and inaccuracies created by conventionalized inguinal anatomy.

Anson, Barry J.; Morgan, Edward H., and McVay, Chester B.: Surgical Anatomy of the Inguinal Region Based upon a Study of 500 Body-Halves, S.G.&O. 6, (Dec.) 1960.

Abdominal Surgery

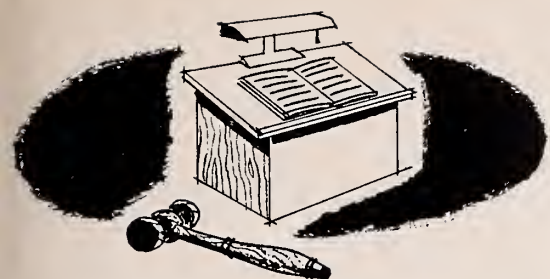
AGAIN THE NEW ENGLAND JOURNAL makes available to the practitioner a comprehensive two-part survey. The present report reflects the general surgical interest in various abdominal problems, and the diagnosis and management by a review of the world's literature.

Welch, Claude E.: Abdominal Surgery, N. Eng. J. Med. 263:1005, 1960.

Obstructive Uropathy

IN ACUTE OBSTRUCTION of the urinary tract with anuria, the patient should undergo urological studies before therapy for acute renal insufficiency or end-stage pyelonephritis is begun.

J.A.M.A. 174:1639, 1960.



president's letter

LOOKING AHEAD: CHALLENGE AND OPPORTUNITY

THE CURTAIN HAS BEEN drawn on the year 1960—and certainly upon reflection it has been a revolutionary and dramatic year, not only for the United States and the world, but for medicine as we practice it in America as well. From the medical profession's standpoint, it has been a year of uncertainties, surprises, criticism, many new problems, and much "soul searching" leading to self examination.

Certainly many of us will welcome the opportunities of a New Year, as people have done since the earliest ancient nations did, such as the Chinese, Egyptians, Romans, and Mohammedans, who all celebrated New Year's Day, although the new year began at different times. January 1 did not become generally recognized as New Year's Day until about 1500 A.D., when the Gregorian calendar was introduced. However, the Hebrews and some few other religious groups and countries still have various other days for the New Year.

The custom of making resolutions to correct faults and bad habits and resolve to make the New Year better than the one just ended goes back to an old English custom of cleaning the chimneys on New Year's Day. This was supposed to sweep out the bad and bring in the good luck to the household in the coming year.

As it is now the beginning of 1961, it is time that we of the Medical Association of Georgia consider some of the most pressing problems and opportunities which we will have to stress in the year ahead and perhaps resolve that we give more concerted effort to solving them to the benefit of all concerned. We should not neglect any of the principles connected with the art and science of medical practice; how-



MILFORD B. HATCHER, M.D.

ever, we should at all times be cognizant of the cost of medical care.

Of paramount importance is still our problem of health care of the aging and we must assume our responsibilities through full cooperation and participation.

We should encourage not only paramedical careers, but we should seek out and encourage the "cream of the crop" of those who we think would make good physicians. We should lend our support to medical education and programs of educational values.

Mental health, with the aid and support of Georgia's Governor S. Ernest Vandiver, has made great strides during 1960. However, we should continue to improve this gigantic mental health situation.

While voluntary health insurance has made great strides, this, like all other health problems, is foremost in the minds of all the people in this country.

PRESIDENT'S LETTER / Continued

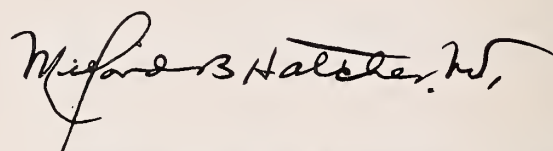
Even the National Intercollegiate Debate topic for 1960-61 is "Resolved: That the United States Adopt a System of Compulsory Health Insurance." Your MAG has material which will assist you to aid the youth of our nation in conducting a fair and unbiased investigation of this topic.

We should not neglect our relationship with our fellow doctors, but should maintain and improve a better "doctor to doctor" relationship. Not only should we improve this relationship, but due to the fact that health care of the public is such a complex field with many other participants besides physicians (some 4,000,000 in the U.S.A.), we should take the lead in improving our liaison with these groups.

Last, but not least, we should evaluate each health

bill which comes before our legislative bodies and lend our support to those which we feel beneficial. Those which in our opinion are detrimental to the best of health, we should oppose. Physicians have been accused too frequently of having a "negative attitude" in the past, so the MAG should take the lead in a positive health program.

Your MAG officers and staff pledge their best efforts in 1961, and we earnestly request the enlightened support of each individual physician in the State of Georgia.



President, Medical Association of Georgia

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Adan, Anibal	Emory University Hosp. Atlanta 22	Active	Fulton
Allman, Fred L.	545 Baptist Prof. Bldg. Atlanta	Active	Fulton
Covington, John M.	Box 187, Med. Bldg. Dallas	Active	Cobb
Fowler, R. W., Jr.	Doctors Bldg. Marietta	Active	Cobb
Griffin, Jack	1525 13th Ave. Columbus	Active	Muscogee
Hardin, Frederick F.	1938 Peachtree Rd., N.W. Atlanta 9	Active	Fulton
Harper, Herbert S.	1453 Harper St., Augusta	Active	Richmond
Iniguez, R. Calixto	V. A. Hospital, Augusta	Active	Richmond
Lawrence, A. L., Jr.	745 Pine St. Macon	Active	Bibb
Payne, Fred W., Jr.	Talmadge Memorial Hosp., Augusta	Active	Richmond
Prater, Harry W.	Jeffersonville	Active	Bibb
Stafford, Gordon O.	2539 Roswell Rd. Marietta	Active	Cobb
Stecker, Donald C.	Burleyson Dr. Dalton	Active	Whitfield
Van Duyn, John	1415 Third Ave. Columbus	Active	Muscogee
Worthy, Jerry L.	Box 187 Dallas	Active	Cobb



heart page

UNUSUAL MANIFESTATIONS OF ACUTE MYOCARDIAL INFARCTION

Thomas D. Johnson, M.D., *Albany*

THE RECOGNITION OF THE typical case of acute myocardial infarction should offer no problem to most of us. However, a substantial number of patients having acute myocardial infarction present with unusual or atypical symptoms that may fail to bring this diagnosis to mind. On reviewing such cases one wonders if many of the unusual presenting symptoms are due to intense stimulation of the autonomic nervous system, and that this in turn is responsible for the symptoms that the patient has. Since the key to minimizing disability is the early recognition of this disorder, it is well to be ever conscious of its occurrence.

Pain remains the hallmark of myocardial infarction. Accordingly, atypical pain is the category in which we find most cases that are unusual. Atypical pain appears to occur more frequently in the very young and the very old individuals. The young man may seek help from his dentist because of a nagging pain in his jaw; particularly if the cause of the pain is not readily apparent, myocardial infarction should be suspected. The case for infarction is nearly complete should the patient faint. Such patients may have no pain in the chest whatsoever, or at times may have pain in the right arm only, to add to the confusion. Other cases in this relatively unusual category include the man who complains suddenly of pain in his arm or shoulder, back or neck, or other areas of the pectoral girdle. This pain is apt to

mimic skeletal pains of bursitis, tendonitis, fibrositis, or be attributed to an old injury or deformity in the upper extremity. If the patient has both a musculo-skeletal cause for pain plus myocardial infarction, we may miss the latter, even though we are conscious of it. Typical cases of acute bursitis or tendonitis have been recalled in whom the patient had a normal electrocardiogram only to find several months later a myocardial infarction occurred around this time without any chest pain. Such occurrence makes one wonder if the tendonitis were not reflexly produced by the developing infarction.

Unusual descriptions of the pain often lead us awry; the pain may be burning in quality, sharp, almost pleuritic, or entirely abdominal in location. Cases are recalled in which the patient appeared to have typical functional gastrointestinal disorders with severe epigastric pain relieved by the injection of an antispasmodic, only to have them return the following day with more typical manifestations of infarction. The radiologist recalls instances of such pain in which he found intense pylorospasm at fluoroscopy which were apparently due to acute infarction which eventuated in sudden death following the x-ray examination, or in which electrocardiograms subsequently became typical. This is the type of situation where autonomic stimulation must be responsible for the abdominal pain through a reflex physiologic mechanism.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Another category of unusual cases would include those who have no pain whatsoever, the so-called "silent infarction." Again the patient almost always is aware that something unusual has happened to him, if we discover the infarction at that time. If the infarction is found some months later when the patient develops congestive heart failure, he may not recall any significant symptoms since he may have attributed them simply to indigestion or a virus. These patients have come to the doctor, however, complaining of shortness of breath, of dizziness, of fainting, or because of an attack of asthma or extreme suffocation due to pulmonary congestion. The easiest patient to miss is the man who overtly hyperventilates with obvious anxiety, and the pitfall is to reassure him that his overbreathing is simply due to anxiety. Therefore, hyperventilation in a man who has been doing well previously should raise the suspicion of infarction. Acute pulmonary edema is a common signal of a myocardial infarction in the Negro, accompanied by a normal or an elevated blood pressure. With the onset of pulmonary congestion or congestive failure, however, the electrocardiogram usually is dependable in revealing the diagnosis, despite the absence of pain.

Other cases in which the electrocardiogram fails to make the diagnosis offer unusual situations. A single electrocardiogram is commonly normal before the typical changes evolve on succeeding tracings. Rarely as many as eight or nine days may pass before the typical changes appear. Thus the suspecting physician must call for not one, but two or more electrocardiograms, if his suspicions are sufficiently strong. A single normal electrocardiogram, therefore, may be of little value in excluding the diagnosis. It should be emphasized that contrary to hope the newer transaminase tests are totally undependable in ruling out infarction.

Occasionally, patients with some of the unusual presenting symptoms may have a situation complicated by the finding of a hiatus hernia, gallstones, a moderate blood pressure elevation, or a chronic history of dyspepsia. These may offer attractive ex-

planations for the sudden event that brought the patient to the doctor. Such cases may be properly diagnosed only by more than one serious evaluation for myocardial infarction.

Occasionally, patients who are in the hospital for other reasons develop myocardial infarction. An episode of postoperative hypotension, hiccups, or dyspnea should arouse one's suspicion. It should be emphasized, however, that pulmonary embolism is more commonly responsible for such episodes, even with an abnormal electrocardiogram. A fever of unknown cause during a hospital stay on occasion is due to infarction. Such fevers may appear to respond to antibiotics because of their natural gradual disappearance over a two to seven day interval.

At times the patient may come in with a stroke associated with blood pressure drop incident to an infarction, with the stroke improving on return of the blood pressure to normal levels. Strokes are also due to "silent infarctions" with cerebral embolism. It is, of course, well known that the peripheral embolus to the extremity most commonly comes from the heart, and this may likely be secondary to an infarction. A case is recalled of a farmer with a small cerebral embolus who refused to accept a heart attack as an explanation for his weakened hand and came to grief as he finished his seasonal planting.

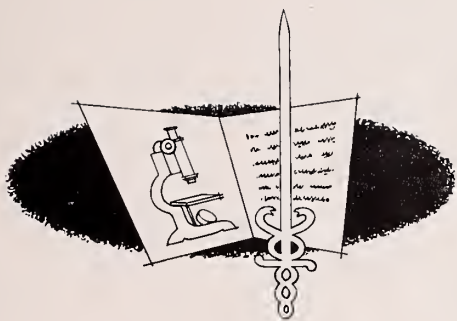
Finally, it is well to re-emphasize the well known fact that myocardial infarction may present with cardiac arrhythmias as their only manifestation, most commonly auricular fibrillation, but also including ventricular tachycardia, simple sinus tachycardia, or with complete heart block and Adams-Stokes seizures.

A plea is made for an attitude of suspicion for myocardial infarction in patients in the proper age group and sex, who present with sudden new symptoms involving not only pains in the chest, pectoral girdle, neck or jaw, fainting, dyspnea, rapid heart action, stroke, peripheral embolization, fever, hypotension, or simply a profoundly weakening drenching sweat. The sudden onset of severe epigastric pain, although suggestive of functional disorders, has also been mentioned. These are all areas in which myocardial infarction may be present.

CHEST PHYSICIANS ESTABLISH FUND TO ASSIST CUBAN MEMBERS

AT THE MEETING OF the Board of Regents of the American College of Chest Physicians held in Washington, D.C. on November 28, 1960, a resolution was adopted to establish a relief fund for Cuban members of the College who have been exiled temporarily from their

country. The Board of Regents voted to contribute \$5,000 to launch the fund and contributions are being solicited from College members and others who are interested. The Cuban Chapter of the College was founded in 1940 and now has 74 members.



cancer page

ROUTINE PROCTOSCOPIC EXAMINATIONS

A. B. Conger, M.D., *Columbus*

AT A RECENT MEETING of the American Cancer Society in Atlanta, there was considerable discussion among the lay delegates over what could be expected when a patient went into a doctor's office and asked for a complete physical examination. This discussion was brought on partly because some of the patients had not received Papanicolaou smears as part of their examination and partly by articles that have recently appeared in lay publications.^{1,2}

After some thought provoking talk, the general consensus of opinion was that a so called yearly check-up should consist of the following:

(1) *A Routine History.* If the patient was making an initial visit this naturally would be much more complete than if there was already considerable knowledge of the patient's background on the chart. At the least, however, it should go over the patient's health history since the last visit with a review of systems.

(2) *A Thorough Examination.* Patient should be completely disrobed and should be checked from top of head to sole of feet. This should include check of eye grounds, check under dentures, visual and manual pelvic and rectal examinations, as well as routine blood pressure determinations, auscultation of the heart, palpation of the neck, breasts and abdomen, and weight.

(3) *Laboratory Work.* As a minimum, a hemo-

globin determination, blood smear, Papanicolaou smear of cervical secretion, routine urinalysis, and chest x-ray should be done.

In many instances, depending on symptoms and past history, other special tests may be necessary. Among these may be an electrocardiogram (which many doctors consider routine), sedimentation rate, basal metabolism rate, various blood chemistry determinations, etc.

And last but not least, it is generally agreed in both lay and medical publication that *a routine sigmoidoscopic examination should be done as part of the yearly check-up, particularly in people over 40.*³ The primary reasons for this examination can be briefly stated in four sentences. (1) About 70 to 75 per cent of all carcinomas of the entire colon can be seen with the sigmoidoscope. (2) Most pathologists generally agree that carcinomas of the colon begin in polyps which may or may not be benign at the beginning, but at least, are small. (3) The cure rate in carcinoma of the colon and rectum is higher than that for any other internal cancer (between 50 and 75 per cent) and is much higher in early lesions than in late ones. (4) Series after series of routine sigmoidoscopic examinations have shown that about five per cent of people over 40 have rectal or sigmoidal neoplasms.

The advent of the small, self contained, dispos-

Approved by Professional Education Committee, Georgia Division, ACS.

able, enema unit has made preparation of the bowel in the office for sigmoidoscopic examination a very simple undertaking. A little experience with the sigmoidoscopic procedure makes it a simple, painless, and rapid examination.

Taking all factors in consideration—the ease with which the procedure can be done, the high yield of

positive results, and the tremendous advantage to the patient of finding these lesions and finding them early—routine sigmoidoscopic examination in patients—is one of the most necessary and gratifying of all examinations.

References

1. Good Housekeeping Magazine, August, 1960.
2. Coronet Magazine, 1958.
3. Neal, Herlitzka, et al., Cancer 12: 833-839, July - August, 1959.

**1961 MAG Roster available at Medical Association of Georgia,
938 Peachtree Street, N.E., Atlanta 9. \$3.00 per copy.**

KENNEDY ADMINISTRATION WILL TRY AGAIN IN 1961

PHYSICIANS ARE BEING URGED to cooperate fully to get their states to participate as soon as possible in the new federal-state program for medical care of needy and the near-needy older persons.

The medical profession also has been alerted to the dangers of relaxing its opposition to tying in medical care of the aged with Social Security. It is probable that the Kennedy Administration will try in 1961 to get Congressional approval of such legislation.

E. Vincent Askey, M.D., President of the American Medical Association, pointed out to the recent Washington meeting of the A.M.A. House of Delegates that proponents of the Social Security approach had a pledge of support from the successful Democratic candidate for President.

"While our profession clearly may face a hard struggle in the 87th Congress on the issue of medical aid for the aged under Social Security, there is no ground for defeatism!" Dr. Askey said.

"Our cause is far from lost. We know that our policy position is in the best interests of all Americans, the aged included, and our willingness to defend this policy must be strengthened and maintained."

Dr. Askey reminded the House of Delegates that "medicine has many friends in both parties in Congress today."

A few days later, Sen. Harry F. Byrd (D., Va.), Chairman of the Senate Finance Committee which handles Social Security legislation, reiterated his opposition to a compulsory medical care plan under Social Security. He said:

"I am opposed to the (Democratic party) platform

recommendation for compulsory medical service and hospitalization under the Social Security system. I am convinced this would lead to socialized medicine with the possibility that it would bankrupt the Social Security trust fund. This matter came before the Finance Committee and was fought out in the post-convention session of Congress last August. The Senate voted 51 to 44 in opposition to the Democratic platform proposal, and instead adopted a fair plan for medical service and hospitalization for those in need of it."

Dr. Askey urged that all county and state medical associations provide "the medical leadership necessary to implement the Mills-Kerr Bill (the new federal-state program) as rapidly as possible." And the House of Delegates adopted such a resolution.

"We must put forth a sincere and concentrated effort during the coming year to make the Mills-Kerr law effective, to show that it can, practically as well as potentially, solve the problem of medical care for the aged," Dr. Askey said.

President-elect John F. Kennedy's first Cabinet appointment was Gov. Abraham Ribicoff of Connecticut as Secretary of Health, Education and Welfare—the official with primary responsibility for carrying out the federal part of the Mills-Kerr program.

Ribicoff, 50, was an early supporter of Kennedy for the Presidential nomination. He was twice elected governor of Connecticut. Before that, he served as a Hartford, Conn., police judge, a member of the state legislature, and a member of the national House of Representatives. As governor, he inaugurated a comprehensive traffic safety program with strong penalties.



Legal page

BLOOD TRANSFUSIONS

John L. Moore, Jr., *Atlanta*

BASIC LAW, with which all doctors will be familiar, states that any surgical procedure requires the consent of the patient or someone authorized to act in place of the patient. This same principle applies to blood transfusions. If the patient is fully able to consent at the time the matter is discussed and does consent, there is no problem. If the patient is a minor or incompetent in some other way, problems may arise. In an emergency, if there is no person competent to act to give the consent for the patient, the doctor is generally said to have the inherent right to act in the emergency and give a blood transfusion. However, if the patient or the proper person or persons to consent for the patient refuse to allow the blood transfusion, the law apparently requires that the physician allow the patient to die, if that is the consequence. Should the physician, despite the refusal to consent, administer blood, the law considers that he has committed a battery upon the patient. This is particularly serious, in case the patient dies, because, by reason of the battery, the physician is held practically to the position of an insurer that the patient would not die.

The problem becomes especially difficult if the patient or the persons who are supposed to consent on behalf of the patient refuse to do so because of religious beliefs. At least one religious sect insists that to receive a blood transfusion is a sin. Members of this sect insist that they would themselves

prefer to die or to have their close relatives die rather than to receive a blood transfusion.

The religious and ethical difficulties are apparent in this situation. Neither the doctor nor any other person wishes to impose his own religious beliefs upon another. Yet, the doctor and the public at large both feel an intense horror at the thought that any person should unnecessarily die because of refusal to receive a blood transfusion.

A recent case in Atlanta received considerable publicity. In that case a hemophiliac received serious injuries from an accident and was bleeding to death in the hospital. The patient's spouse, because of religious beliefs and reasons, refused to consent to blood transfusions necessary to give the patient a chance to live. In this particular case, after one unsuccessful move in court, the relatives applied to the Court of Ordinary to declare the patient of unsound mind to the end that a guardian of the person could be appointed. This procedure was followed and the spouse, though unwilling to consent to the blood transfusion itself, was willing to waive the required ten days notice of the hearing. Thereupon the statutory Lunacy Commission examined the condition of the patient and determined that, for physiological reasons, the patient was of unsound mind. A court then appointed a guardian of the patient's person. The guardian immediately signed a consent on behalf of the patient and transfusions were begun.

Prepared at the request of the Medical Association of Georgia. Mr. Moore is an associate in the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.

Another interesting possibility is the case of the pregnant mother with the wrong Rh factor. If the medical indications are that the child will have to be completely transfused at birth and the mother has religious scruples against allowing blood transfusions, a very serious problem arises. The procedure used with the Atlanta hemophiliac is of no possible use. However, the provisions setting the duties of the juvenile courts in Georgia state that the juvenile court shall have original jurisdiction concerning any child under 17 years of age living or found within the county who is neglected or in need of medical, psychiatric, psychological or other care necessary for his well-being. Certainly, if a child of five years of age needed a blood transfusion and the patient's parent wilfully neglected to take the child to a

doctor, this provision would be applicable. If the question arises before the birth of a child, it would seem to this writer, from general principles of law, that nothing could be done in court until the child is born.

Since it is preferable to transfuse a newborn baby with Rh complications immediately and usually no later than 12 hours after birth, there is obviously a difficulty in persuading the court to act. However, it would seem to the writer that the position could be taken before the juvenile court that the newborn baby was neglected and in need of medical care necessary for his well-being. Whether the court would act would depend on how the court considered the religious issues involved and it is not possible to foresee the result of such a hypothetical case. The writer would express a strong hope that the court would take jurisdiction and enter the necessary orders.

NOTES FROM WASHINGTON

F.D.A. Cleared of Conflict-of-Interest

Food and Drug Administration employees have been cleared of conflict-of-interest charges brought up in the Senate Antitrust and Monopoly Subcommittee's investigation of the drug industry.

A three-member investigating group appointed by Arthur S. Flemming, Secretary of Health, Education, and Welfare, examined the financial records of 900 F.D.A. employees. The special investigators then reported:

"On the basis of all the evidence before us, it is our judgment that there are no present employees of the F.D.A. whose sources of personal income are incompatible with their government employment."

The investigators continued to analyze "a mass of fact and opinion" in connection with charges that there has been too close a relationship between some F.D.A. employees and drug companies which they check for conformance to government regulations.

The investigators anticipated that their final report would show the possibility of organization or procedural improvements of the F.D.A.

The charges were triggered by disclosure at the Subcommittee investigation that Dr. Henry A. Welch, Director of the F.D.A.'s Antibiotics Division, has received \$287,000 over eight years as a writer and editor

for antibiotics publications. After the disclosure, Flemming ousted Welch from the government post.

Infant Death Rate Declines

The Federal Children's Bureau reported that the infant death rate in the United States has declined since 1958 but still shows the effect of a 1957-'58 setback.

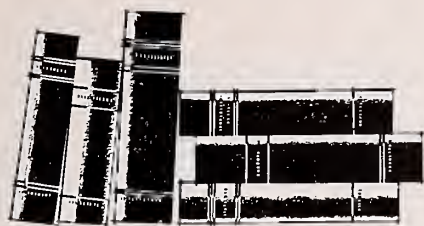
There was a steady decline in U. S. infant deaths during the 1950's but increases in 1957 and 1958. Since then, the infant death rate has headed downward again but still hasn't made up the lost ground, even though the provisional rates for 1959 (26.4 per 1,000) showed improvements.

In 1915, when data were first gathered on infant mortality in this country, the rate was 99.9 per 1,000. By 1940, this had been cut to 47 and by 1950, it had been reduced to 29.2.

An all-time low of 26 was registered in 1956. It edged up to 26.3 in 1957 and 27.1 in 1958.

According to the 1959 United Nations Demographic Yearbook, nine other countries reported lower infant mortality rates than the United States in 1958. They were: Sweden 15.8, Netherlands 17.2, Australia 20.5, Norway 20.5, Switzerland 22.2, United Kingdom 23.3, Denmark 23.4, New Zealand 23.4, and Finland 24.5.

Russia reported a rate of 81 in 1950 and 40.6 in 1957, latest year for which data were reported.



physician's bookshelf

BOOKS RECEIVED

Valensin, Georges, M.D., *THE QUESTION OF FERTILITY*, Doubleday & Co., Inc., Garden City, N. Y., 1960, 296 pp., \$4.50.

Abramson, Harold, M.D., *RESUSCITATION OF THE NEWBORN INFANT*, The C. V. Mosby Co., St. Louis, Mo., 1960, 274 pp., \$10.00.

Quigley, Thomas B., M.D. and Banks, Henry, M.D., *PROGRESS IN THE TREATMENT OF FRACTURES AND DISLOCATIONS 1950-1960*, W. B. Saunders Co., Philadelphia, Pa., 1960, 102 pp., \$2.50.

Krugman, Saul, M.D. and Ward, Robert, M.D., *INFECTIOUS DISEASES OF CHILDREN*, The C. V. Mosby Co., St. Louis, Mo., 1960, 398 pp., \$13.00.

Wolstenholme, G. E. W., O.B.E. and O'Connor, Cecilia M., B.Sc., *CIBA FOUNDATION STUDY GROUP NO. 5, REGULATION OF THE INORGANIC ION CONTENT OF CELLS*, Little, Brown, and Co., Boston, Mass., 1960, 100 pp.

Eysenck, H. J., Ph.D., *BEHAVIOUR THERAPY AND THE NEUROSES*, Pergamon Press, New York, N. Y., 1960, 479 pp., \$10.00.

Gunzburg, Herbert C., Ph.D., *SOCIAL REHABILITATION OF THE SUBNORMAL*, The Williams & Wilkins Co., Baltimore, Md., 1960, 263 pp., \$6.50.

Kahn, Theodore C., Ph.D. and Griffin, Martin B., M.D., *PSYCHOLOGICAL TECHNIQUES IN DIAGNOSIS AND EVALUATION*, Pergamon Press, New York, N. Y., 1960, 164 pp., \$6.50.

Smith, Carl H., M.D., *BLOOD DISEASES OF INFANCY AND CHILDHOOD*, The C. V. Mosby Co., St. Louis, Mo., 1960, 572 pp., \$17.00.

Meares, Ainslie, M.D., *THE SYSTEM OF MEDICAL HYPNOSIS*, W. B. Saunders Co., Philadelphia, Pa., 1960, 484 pp., \$10.00.

REVIEWS

Scholz, Roy O., M.D., *SIGHT: A HANDBOOK FOR LAYMEN*, Doubleday & Co., New York, N. Y., 1960, 166 pp., \$3.50.

INCREASED LAY INTEREST in medical problems of diagnosis, prognosis, and treatment, evidenced by current articles in most periodicals, has stimulated the evolution of this new handbook on sight by Dr. Scholz.

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

Most of the varied problems concerning the eyes are discussed with experienced authority and exposure of many popular misconceptions makes interesting patient reading—or student reading. The concepts of therapy and surgery cover the essentially good procedures without confusing technical language. Systemic disease effects on the eyes will be appreciated by everyone and other discussions of special optical problems, contact lenses advisability, and newer drug therapy seem adequately clear—with a glossary of terms anyone will understand.

Thanks to Dr. Scholz, we now have available a layman's answer-book for problems of sight; concise, complete, well advised to those who ask or answer questions regarding eyes.

W. Granville Tabb, Jr., M.D.

Cohn, Isidore, M.D. and Deutch, Hermann B., *RUDOLPH MATAS, A BIOGRAPHY OF ONE OF THE GREAT PIONEERS IN SURGERY*, Doubleday & Co., Inc., Garden City, N. Y., 1960, 431 pp., \$5.95.

RUDOLPH MATAS by Isidore Cohn, M.D., with Hermann B. Deutsch is one of the most interesting biographies that I have encountered. It not only is a biography of a great man in surgery, but it is, also, a wonderfully recorded history of medicine from the time of the Civil War to our atomic era. This book is easy to read, moves rapidly, and is written in a clear style. A beautiful story is told of his father's devotion to him and of Rudolph's response. A tragic story is entwined with that concerning his mother and his sister. His courtship with his wife and their eventual marriage point out strongly the dogmas of his day and his feeling toward these dogmas.

This book reveals that Dr. Matas was not only a surgeon, but he was, also, a great physician as well, interested in all phases of medicine—medical literature, medical politics, in many phases of internal medicine, and in preventive medicine.

Dr. Cohn did an excellent job in writing this biography. It is very evident that it was written by someone who knew Rudolph Matas well and, also, someone who loved and admired him.

Stewart M. Long, M.D.



mental health page

MASTURBATION

Gabriel d'Amato, M.D., *Savannah*

THE ENTIRE SUBJECT of masturbation and the related forms of solitary sexual gratification have been studied by educators, pediatricians, and psychoanalysts. In the 19th Century masturbation was seriously considered an etiologic factor in epilepsy and insanity and we now read with amusement that "many of the symptoms presented by the inveterate masturbator are probably due to cerebral anaemia" (Pepper's *Practical Medicine*, Volume V, 1886). However, as recently as 1926, Ziehen stated that masturbation caused "infantile neurasthenia." By the time Freud developed his early ideas regarding the nature of anxiety and neurosis, it was inevitable that these ideas of harmfulness overshadowed his initial formulations. A few of the psychoanalytic discussants around 1912 were interested in the accumulation of "sex toxins," but soon enough the question of guilt and conflict entered the picture; the focus shifted to the "struggle against masturbation." Now it is easy to see how during the next few decades the pendulum had swung to the other side and how it came about, among the sophisticated, that masturbation was treated very superficially, the chief concern being how to release the adolescent from his masturbatory guilt feelings.

A remarkable idea concerning the nature of these guilt feelings was put forth in recent years by Fromm-Reichmann. She noted that many children who were never subjected to any warning against masturbation and many adults who in awareness did not regard masturbation as forbidden, nevertheless, would feel guilty or anxious if they mastur-

bated. Why? Many cases seemed to be connected with the fact that the masturbatory act signified the child's very first act of independence from his parents. Up to that point the child had to ask for permission to have fun. He had to earn the privilege of fun and play and had to depend on grownups for fulfillment of nearly all satisfactions. Now there comes a time when the child can choose if and when he has the fun; he discovers that he no longer needs to earn permission; the entire matter is secret and thereby gives a feeling of power over the previously all-powerful adults; many "injustices" collected over a day can be counteracted by this secretive and rebellious and willful act and one does not need to get permission to have the fun. The act becomes a consolation which is self-administered, and without parental help. This fact, indeed, of breaking away from one's needed and loving parents then constitutes the basis for guilty fear in connection with forbidden sexual play, regardless of whether the parents are indifferent or punitive with respect to masturbation.

The writer's experience in treating adolescents who have such guilty fears, presumably enacted through masturbatory acts and fantasies, is as follows. The issue of masturbation is never explored directly and in general avoided, whenever possible. One of the greatest fears of the adolescent in the middle or later adolescent period, derived from movies, television or reading, is that the physician is wound up and ready to discuss nothing but sex. These youngsters are tremendously gratified and gratefully relieved when they discover that the therap-

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

ist is interested in talking about some quite real and practical problems which up to this point had escaped notice or had not been considered really important. And this common place problem so often is the issue of self-realization and independence and the ventilation of hostile feelings towards authority figures. Once this material is "worked through," there is, you see, no need to approach the guilt-ridden play-acting of masturbation.

It is important for the physician who deals with children to recognize that parents usually have a most difficult time accepting sexual misbehavior particularly in their own child. *Knowledge* about sex matters does not match those perduring *feelings*. This was perhaps dramatically illustrated when a physician came to borrow Kanner's classic textbook *Child Psychiatry* in order to read the chapter on problems of sexual behavior. He was worried about his child's masturbation and he was willing to read about it and discuss it; yet, the real feelings and conditioned fears which added to the parental anxiety were never resolved. In fact, the avoidance of feeling was obvious through the parent's use of a purely "scientific" and intellectual attitude. Kanner himself pointed out that parents almost always introduce the complaint of masturbation by a succeeding clause or statement which reflects the moral or judgmental attitude. Practice shows that it is most rewarding to take additional time and patience to understand the parent's feelings, to be interested tactfully and sincerely in the parent's own personal past and training and experiences, and to be of inestimable help thereby in integrating for this parent his own past distortions and painful experiences with the present. Parental anxiety can thus be seen not as a failure but as a challenge which invites change, a change of feeling. The physician should empathically uncover for the patient those personal issues and feelings which previously, for lack of trust and rapport, could not be disclosed. It seems desirable to conclude that a parent whose own personal fears and distortions have been removed would certainly be in a stronger and more wise position, better able from then on to cope with the child's problem and to become a co-operative parent.

Certain time-tables and developmental facts are always helpful in understanding much that is human. And so in the case of masturbation we read again and again that small infants explore their bodies.

This writer has the impression that there is a wide range of variation in infants based on constitutional capacity for greater or less mobility, greater or less curiosity, and such determinants, in addition to local factors such as skin or mucosal irritation.

The famous oedipal period then again becomes a time for recapitulation of body stimulation. As the normal play activities of a child change from exploratory or sensory-motor, to imitative, to dramatic, so it seems logical to assume that masturbatory play at this period is accompanied by fantasies. Following the developmental expectations, mutual masturbatory activities may normally occur during the elementary school period when children, in their latency, are attempting to form chums and learn to socialize.

As fantasy life is a most important part of adolescent experimentation, a detour to reality (Hartmann), so do the sexual activities remain secret and in fantasy. With the attainment of heterosexual endocrine and personality development, masturbation is abandoned. Here the question arises in connection with the prevalence of excessive kissing, necking, petting, mutual manipulations and such things which comprise all sorts of transitions between childhood masturbation at the one extreme and the strivings for romantic erotic expression at the other. One can see how increasingly complex the behavior becomes and, therefore, how much more possible whatever psychopathology, if present. These matters are further complicated by the existing cultural practices and expectations.

The physician to the family can be a great source of help in the process of sexual education of children. With adults the matter is no different than the problem of studying any other kind of behavior. Masturbation may be a gratifying temporary tensional outlet in certain circumstances; it may be attended by reaction or attitudes that require psychiatric work; the connected fantasies may indeed become highly revealing and do often provide opportunity for skilled psychotherapeutic intervention since such fantasies tell the therapist of the inner life of the patient and of how the patient wishes to or expects to cope with other people. Through such fantasies the patient may show what troubles he has with intimacy, human closeness, or his very existence as a person.

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Gardner, Edward, Jr., Ph.D.; Wright, Claude-Starr, M.D., and Williams, Bettie Z., B.S., Medical College of Georgia, Augusta, Georgia, "An Evaluation of the Urine Hydrolysis Test for Primitive White Blood Cell Differentiation," J. Lab. & Clin. Med. 55:883-896 (June) 1960.

Conditions affecting the use of urine hydrolysis for the differentiation of white blood cells are discussed and findings indicate pH, temperature, and time are the most important factors to be controlled.

Observations on the effect of purified enzyme preparations in an attempt to duplicate the effect of urine revealed that only desoxyribonuclease (DNase) in buffered saline gave comparable results.

Application of the urine test to blood films from a variety of hematologic patients substantiated the validity of the differential action in lysing cells of the neutrophilic series. The selective action was apparent in the very young cells of this series and was judged of value as an aid to cell identification.

Additional studies concerning identification of the responsible enzymes and the relationship of the enzyme concentration in urine to pathologic conditions are in progress.

Exposure of lupus erythematosus (L.E.) cells to the action of urine presented a variable picture on different parts of the cell. These variations may represent a difference in the cell type from which the L.E. cell is derived.

Raoney, Donald, M.D., Kennestone Hospital, Marietta, Georgia, "Post-Voiding Films as an Aid to Opacifying the Obstructed Ureter," J. Urol. 84:300-306 (Aug) 1960.

Radiologists and urologists are frequently confronted with the problem of unilateral non-visualization on an intravenous urogram. This report discusses a simple technique which is helpful in more promptly opacifying the obstructed ureter.

When ureteral obstruction is suspected following inspection of the routine excretory urogram films, and if there is any opacification of the calices, the patient is instructed to walk to the rest room and urinate. After returning to the radiographic room, a supine post-voiding film is made. If there is no opacification of the involved kidney on the routine films, post-voiding films are delayed for one hour or even several hours later until some caliceal opacification occurs. This technique has

been used for several years and has been helpful not only in more promptly opacifying the obstructed ureter, but of even greater importance, it frequently discloses or confirms the exact site of obstruction by opacifying the ureter right down to the obstructing lesion. Since the involved ureter may opacify more promptly, fewer follow-up films are necessary, thereby helping to conserve radiation exposure to the patient, radiographic film, and time.

Physiologic mechanisms producing ureteral opacification in the presence of obstructive uropathy are discussed and are illustrated with several representative radiographs.

By individualizing the I.V.P. in this manner to suit each patient with a particular problem, one is able to extract the maximum amount of useful diagnostic information from this examination.

Greenblatt, Robert B., M.D. and Martinez, O. Morena, M.D., Medical College of Georgia, Augusta, Georgia, "The Role of Corticoids in Osteoporosis," Ger. 15:555-562 (Aug.) 1960.

This article describes five cases of osteoporosis of varying etiology and discusses results of treatment in each. Attention is called to the role of corticosteroids in the induction of osteoporosis and to the possible aggravation of pre-existing osteoporotic conditions. A warning is sounded as to the necessity for judicious use of corticoids and the advantages of supplementing their use by anabolic hormones such as androgens and estrogens in an attempt to minimize their catabolic effects on bone mineralization. The relationship of osteoporosis to certain endocrinopathies, i.e., hypo-ovarianism and Cushing's disease, is discussed. Current concepts as to the mechanisms at work in the metabolic activity of living bone tissue are reviewed.

Williams, George A., M.D.; Taniette, Sallye J., M.D., and Velarde, Alansa, M.D., 710 Peachtree Street, N.E., Atlanta 8, Georgia, "Primary Carcinoma of the Fallopian Tube," South. M. J. 53:1253-1257 (Oct.) 1960.

Primary carcinoma of the fallopian tube is rather uncommon, only 560 cases having been reported. Five-year survivals are about five per cent. Pre-operatively diagnosed cases number only about six and indicate the gravity of the problem, most patients reaching

incurability before treatment is instituted.

There are no specific early signs or symptoms. The growth may mimic benign lesions and associated pathology frequently obscures the pelvic picture.

Six cases are reported from a ten-year experience at the Crawford W. Long Memorial Hospital. The age range was 35 to 72 years. Treatment by five different operators was varied. Two patients were treated with total hysterectomy, bilateral salpingo-oophorectomy, and adequate postoperative x-radiation survived, apparently free from the disease, for two years and ten years. Another was alive at two and one-half years, but had abdominal recurrence. The other three died from two to nine months postoperatively.

The authors think the answer to the problem lies in earlier diagnosis. An occasional case may be brought to light by cytologic studies, even though the tubes are blocked in most patients. Adnexal masses and abnormal discharges in postmenopausal women should never be allowed to go undiagnosed, even though laparotomy evaluation may be required.

Bennett, Truett, M.D., Ponce de Leon Infirmary, Atlanta, Georgia, "Laryngeal Strictures," South. M. J. 53:1101-1104 (Sept.) 1960.

Strictures of the larynx due to scar tissue may be the result of trauma, infection, or any condition that will cause loss of cartilage and scarring. Rehabilitation is most rapid with open surgery. If there is loss of cartilage, a bone graft, utilizing the body of the hyoid bone, may be used to give more space. If, after excising the obstructing scar, there is an appreciable non-epithelialized area, best results are obtained by using a split thickness graft, using a sponge rubber stent to keep the graft in place. In either type procedure, the use of an acrylic stent in the larynx for about six months is necessary. Five cases are presented.

Lionakis, Basil, M.D.; Gray, Stephen W., Ph.D.; Skandalakis, John E., M.D. and Akin, John T., Jr., M.D., Piedmont Hospital, Atlanta, Georgia, "Intussusception in Infants and Children," South. M. J. 53:1226-1235 (Oct.) 1960.

One hundred fifty-nine cases of intussusception in infants and children occurring in Atlanta between 1929 and 1958 are analyzed. Where the four

cardinal signs of pain, vomiting, bleeding, and abdominal mass were present, 90 per cent of the cases were diagnosed correctly. Absence of a palpable abdominal mass was the chief cause of mistaken or delayed diagnosis.

Seasonal fluctuations in incidence are related to climate in that the fluctuations are more marked in cities with the greatest seasonal differences of temperature. Atlanta occupies a middle position among the cities examined.

Boys are affected twice as frequently as are girls, but the mortality rate is the same for both. Mortality in Atlanta declined from 25.0 per cent in the 1930's to 9.1 per cent in the 1950's.

Three factors tending to increased mortality are the youth of the patient, the duration of the condition, and the length of the intestine involved. Each of these factors acts as an independent variable.

The old controversy between hydrostatic and surgical reduction need not be resolved in favor of either. A procedure is suggested which permits the patient to have the advantage of both methods.

Bennett, Truett, M.D., 144 Ponce de Leon Avenue, Atlanta, Georgia, "Laryngeal Trauma," Laryngoscope 70:973-982 (July) 1960.

Injuries to the larynx and trachea may be classified as: (1) lacerations and stab wounds, (2) crushing injuries, and (3) loss of substance by avulsion or gun-blast, etc.

In treatment of the acutely traumatized larynx, consideration of the airways is, of course, the most obvious need. If there is any obstruction at all, a tracheotomy should be considered, because the obstruction will probably get worse over the first 24 to 48 hours. In open wounds, conservation of all cartilage fragments and careful approximation is very important. A plastic stent placed in the larynx for four to six weeks may be necessary to prevent stenosis.

The sequela to laryngeal trauma may be a chronic cicatricial stenosis which may require open surgery with grafting of bone or skin, or both, in order to reconstruct an adequate lumen. Five cases are presented.

Coppedge, W. W., M.D. and Hasty, Lewis B., M.D., 308 W. Cleveland Avenue, East Point, Georgia, "Estrinism in a Girl Two and One-half Years of Age," Am. J. Obst. & Gynec. 80: 637-640 (Oct.) 1960.

This is a case report of a two and one-half-year-old white girl who first had definite breast development and then started with essentially normal monthly menstrual periods. There was slight fuzzy hair on the pubis and in axillae. The clitoris was not hypertrophied but larger than normal for this age. Ab-

dominal examination was negative and rectal examination failed to reveal any pelvic mass. Positive laboratory findings were Papanicolaou smears showing high estrogen levels and no progesterone effect; x-ray long bones, "bone age at least five years." Other complete laboratory studies are included in report. Tentative diagnosis was granulosa cell tumor. Under general anesthesia, suction biopsy of endometrium obtained and exploratory laparotomy done. The uterus, tubes, and ovaries were two to three times normal size for this age. The ovaries were polycystic, but no distinct ovarian tumor was seen. Wedge resections of both ovaries were done. The left ovary contained one small three mm. yellowish area deep in the stroma. The pathological report revealed proliferative endometrium and ovarian tissue revealed no distinct tumor, but a hyperactivity of ovarian stroma called "thecosis." Menses ceased after the operation, but began to recur at monthly intervals about three and one-half months later. At this time follicle stimulating hormone and estrogen level studies were obtained, both showing levels consistent with those of an adult menstruating woman. Since the follicle stimulating hormone level is considered to be zero until the age of puberty, the final diagnosis is a constitutional type of precocious puberty rather than some type of functioning ovarian tumor.

McLendon, Harold, M.D. and Bottomy, John R., M.D., 115 Ambulance Drive, Carrollton, Georgia, "A Critical Analysis of the Management of Pregnancy in Diabetic Women," Am. J. Obst. & Gynec. 80:641-653 (Oct.) 1960.

This study is composed of 170 pregnancies occurring in 106 diabetic patients over a nine-year period at Grady Memorial Hospital. Total fetal survival rate was 66.6 per cent, and viable fetal salvage rate was 76 per cent. The abortion and premature rates were only slightly higher than that of the over-all clinic group; malformations were only slightly higher than the normal expectancy. Acidosis was present in 16.2 per cent of the cases in which intrauterine death occurred with a fetal survival rate of only 53.8 per cent. Toxemia and essential hypertension did not take their expected toll. The White system of classification did not aid in predicting fetal prognosis. Stilbestrol used in 50 cases did not reduce the incidence of acidosis and toxemia.

The high incidence of intrauterine death suggests a more radical trend in the direction of early termination until the neonatal and intrauterine death rate more nearly approach each other. Termination of pregnancy should be considered in all diabetic patients after the 35th week of gestation when the infant has attained an estimated ideal

weight of approximately 3,500 grams, or when interruption is indicated by other complicating factors, either maternal or fetal.

Williams, George A., M.D., 710 Peachtree Street, N.E., Atlanta 8, Georgia, "Endometriosis of the Cervix Uteri—A Common Disease," Am. J. Obst. & Gynec. 80:734-741 (Oct.) 1960.

Endometriosis is usually said to involve the cervix uteri very rarely, but the author's report of 111 cases occurring in his private practice demonstrates it to be a common disease. It can be diagnosed readily at the time of the onset of the menstrual flow or shortly thereafter. At that time, however, the lesions, which are usually superficially implanted on the cervical stroma, are bleeding and undergoing necrosis, making them quite fragile. Special biopsy technique involving minimal trauma with the use of sharp instruments and careful handling of the specimen is described.

The disease itself is trivial, but may produce symptoms which are not only annoying but are alarming to the patient. Trauma, either obstetric or operative, especially cauterization, is probably an etiologic factor. Treatment is by cauterization or fulguration of the lesions and is usually successful.

An extremely high incidence of decidual reaction of the cervix in 85 per cent of patients who subsequently became pregnant suggests a casual relationship because this phenomenon is usually stated to occur in only 10 per cent of pregnant women.

Krugman, Philip I., M.D. and Fisher, J. Edward, M.D., 950 W. Peachtree Street, N.W., Atlanta 9, Georgia, "Primary Carcinoma of the Fallopian Tube," Am. J. Obst. & Gynec. 80:722-726 (Oct.) 1960.

Primary carcinoma of the fallopian tube is a rare malignancy of the female genital tract. Two additional cases of this disease are reported herein.

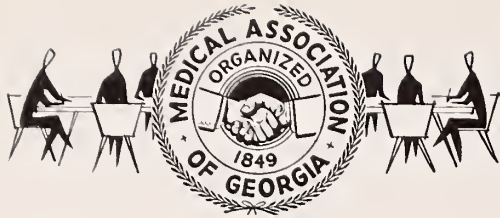
Emphasis is placed upon early diagnosis of this malignancy. The history is fairly characteristic and conforms to a triad of symptoms: (1) profuse serosanguinous vaginal discharge; (2) cramping lower abdominal pain, and (3) abdominal enlargement or tumor.

The vaginal cytology smear is of value in detecting this disease at an early stage. One case reported in this paper was suspected preoperatively on the basis of positive vaginal cytology.

Total abdominal hysterectomy and bilateral salpingo-oophorectomy is the treatment of choice. The present trend is also directed toward the postoperative use of radiation.

The prognosis in this disease is very poor because of difficulty in early diagnosis.

**1961 MAG Roster available at Medical Association of Georgia,
938 Peachtree Street, N.E., Atlanta 9. \$3.00 per copy.**



the association

DEATHS

JOHN E. SAADE, formerly of Atlanta, died November 20 at his home in Augusta at the age of 31.

Dr. Saade was a graduate of Emory University School of Medicine. He took his internship at Grady Memorial Hospital and was a resident there before entering the Air Force, where he served as a captain.

He was a member of St. Elias Eastern Orthodox Church in Augusta.

Survivors include his wife, the former Miss Terry Forte of Nashville, Tenn.; a daughter, Lisa Lynn Saade, Atlanta; his parents, Mr. and Mrs. Betrus Saade, Atlanta; a brother, Joseph Saade, Atlanta, and two sisters, Mrs. R. E. Barber and Mrs. J. J. Pampalon, both of Atlanta.

WILLIAM WALTER SHARPE, III, formerly of Waycross, died at his home in Alma November 16, at the age of 55.

Dr. Sharpe attended Emory University and was a graduate of the Medical College of Georgia. He was a member of the Kappa Alpha fraternity and the Alpha Kappa Kappa medical fraternity.

At the time of his death, he was chief of staff of the Bacon County General Hospital and was a former surgeon of Atlantic Coast Line Hospital in Waycross.

Dr. Sharpe was director of the Citizens State Bank of Alma and was a member of the Ware County Medical Society, Waycross Elks Lodge, past master of the Bacon Masonic Lodge, past ambassador of the Alee Shrine Temple, a lieutenant colonel on Gov. Ernest Vandiver's staff, and a past chairman of the Board of Stewards of the Alma Methodist Church.

Survivors include his wife, the former Louise Varner; two daughters, Mrs. Dan Cabaniss, Decatur and Mrs. Alfred E. Lee, Waycross; two sons, William Walter Sharpe IV and Bruce Sharpe, both of Alma; his mother, Mrs. Charles G. Conn, Waycross; a sister, Mrs. C. H. Hicks, Decatur, and three grandsons.

W. H. WHITTENDALE, 82, prominent retired Norman Park physician, died November 10, at a hospital in Moultrie.

Born in Augusta, Dr. Whittendale moved to Norman Park in 1916, where he practiced medicine for 42 years

and retired in the spring of 1958 because of failing health.

Dr. Whittendale was a member of St. Johns Episcopal Church in Moultrie.

Survivors include two daughters, Mrs. R. J. Lenihan, Moultrie and Mrs. R. J. Aven, Guantanamo Naval Base, Cuba; a sister, Miss Alice Whittendale, Augusta, and four grandchildren.

SOCIETIES

The November meeting of the DE KALB COUNTY MEDICAL SOCIETY and its Woman's Auxiliary was held at Pritchett's Restaurant and devoted to medical legislation on a state and national level.

At a recent meeting of the DOUGHERTY COUNTY MEDICAL SOCIETY, held at the Phoebe Putney Memorial Hospital, a stimulating discussion was held on problems of stroke rehabilitation.

New officers of the FULTON COUNTY MEDICAL SOCIETY, elected at their December meeting, are: J. G. McDaniel, president; Tully T. Blalock, president-elect, and John T. Godwin, vice-president. Their Anniversary Banquet was held in January at the Piedmont Driving Club, with Dr. Noah Langdale, Jr. as guest speaker.

The Anniversary Meeting of THE GEORGIA MEDICAL SOCIETY was held in December.

The HALL COUNTY MEDICAL SOCIETY sponsored the 1960 Diabetes Detection Drive, which was held in Gainesville during Diabetes Week in November.

The officers for 1961 for the LAURENS COUNTY MEDICAL SOCIETY are: B. B. Barmore, president; Fred Coleman, vice-president, and Quentin Price, secretary.

James W. Rhea was named president-elect of the MUSCOGEE COUNTY MEDICAL SOCIETY during their November meeting. Other officers elected for 1961 were: Edgar Horn, president; Bruce Newsome, secretary, and A. J. Kravtin, R. A. Chipman, and John Deaton, delegates to M.A.G.

"Symposium on Heart Disease" was the theme of the Christmas meeting of the THOMAS-BROOKS

MEDICAL SOCIETY, held at the Archbold Memorial Hospital in Thomasville.

The following officers of the WALKER-CATOOSA-DADE MEDICAL SOCIETY were elected for 1961 at a recent meeting of the society: Jerome P. Sims, Ft. Oglethorpe, president; Robert T. Jones, Lafayette, president-elect; Leroy Sherrill, Rossville, secretary-treasurer, and Howard C. Derrick and Hart S. Odom, both of Lafayette, delegates to M.A.G.

The WARE COUNTY MEDICAL SOCIETY met in December at the Green Frog with Ansley Seaman, Leo Smith, and Vilda Shuman as hosts.

The WAYNE COUNTY MEDICAL SOCIETY and Auxiliary met in November with Dr. and Mrs. Carter Meadows as hosts.

Dr. Rudolph Kampmeier, professor of medicine at Vanderbilt University Medical School, addressed the members of the SIXTH DISTRICT MEDICAL SOCIETY, during their meeting in November held at the Elks Club in Macon.

PERSONALS

First District

H. WILDER SMITH, Swainsboro, has been elected chairman of the Swainsboro Board of Education.

THOMAS WARING and RUTH WARING, Savannah, recently participated in a postgraduate course concerned with fractures in general practice held at the Medical College of Georgia in Augusta.

GEORGE D. DAME, formerly of Metter, has entered public health work in Florida.

Second District

"Dr. Jack's Day" was proclaimed in November by the citizens of Blakely and Early County honoring JACK GUY STANDIFER, of Blakely.

MARTIN BAILEY, Cairo, recently attended a postgraduate course at the Medical College of Georgia on fractures in general practice.

EDWIN M. GRIFFIN, of Bainbridge, has moved to his new office at 1502 Evans Street.

WILLIAM J. McANALLY, Thomasville, recently spoke to the members of the Thomas-Brooks County Medical Auxiliary about civil defense medicine.

FRANK K. NEILL, Albany, has been re-elected president of the medical staff at Phoebe Putney Memorial Hospital. Other officers elected are: E. S. ARMSTRONG, vice-president, and JOHN S. INMAN, JR., secretary-treasurer.

Third District

LIONEL M. YOE, of Columbus, recently spoke to the Columbus Lay Society of the Georgia Diabetes Association on "Eyes and the Diabetic."

W. R. BAKER, Hawkinsville, recently moved into his new office, which adjoins Taylor Memorial Hospital.

W. G. ELLIOTT, Cuthbert, recently spoke to the Cuthbert Rotarians on Rotary history, Rotary doc-

trines and their origins, and Rotary requirements of its members.

"Problems of the Aged" was the topic HARRY BRILL, Columbus, chose when he spoke to the Woman's Auxiliary to the Muscogee County Medical Society recently.

ROBERT C. PENDERGRASS, Americus, recently spoke to the Columbus Kiwanis Club on the prison at Andersonville during The War Between the States.

Fourth District

T. ASBURY SAPPINGTON, of Thomaston, recently visited in Ft. Ganes, his original home.

Fifth District

JOSEPH H. DIMON, Atlanta, recently participated in a panel discussion during the Second Annual Conference of the Georgia Rehabilitation Association held at the Academy of Medicine in Atlanta.

SIDNEY ISENBERG, Atlanta, recently spoke at the Academy of Medicine in Atlanta, his lecture being held as a feature of Alcoholism Information Week.

ALEXANDER D. LANGMUIR, Atlanta, recently spoke to the Sarah Rawson Smith P.T.A. on "Medical Impressions in the Soviet."

Sixth District

JAMES EMORY BAUGH, Milledgeville, recently spoke to the Dublin Rotary Club on his trip to the Soviet Union.

Seventh District

JOHN W. LOOPER, of Dalton, was guest speaker at a meeting of the Jasper Lions Club held in December.

ROBERT P. COGGINS, of Marietta, discussed diseases of the heart and blood vessels at the November meeting of the Rockmart Rotary Club.

Recently LESTER J. MARTENS, Rome, spoke to the Piedmont School P.T.A. on "Heart Defects."

Eighth District

R. E. MILLER, of Jesup, was recently appointed Federal Aviation Authority Medical Examiner by Office of Civil Air Surgeon.

Latest developments in medical science for the treatment of heart defects were discussed recently before the Waycross Rotary Club by ARTHUR M. KNIGHT, of Waycross.

E. ADAM DANEMAN, Waycross, was the principal speaker at a recent meeting of the Ware County Medical Society.

Ninth District

HENRY S. JENNINGS, JR., Gainesville, was recently elected president of the Hall County Medical Society.

DR. and MRS. D. C. KELLY, of Lawrenceville, celebrated their Golden Wedding Anniversary in November.

HENRY H. McNEELY, Toccoa, recently attended the postgraduate course concerned with fractures in general practice held at the Medical College of Georgia in Augusta.

Tenth District

A. W. SIMPSON, of Washington, was recently honored when his many friends in the community at-

tended an Open House in the observance of his 85th birthday.

HARRY B. O'REAR, Augusta, spoke to the Augusta Kiwanis Club on "Medical and Health Education in Georgia" in November.

ROBERT B. GREENBLATT, Augusta, was the featured speaker at the November meeting of the Medical Dames of the Student American Medical Association Auxiliary, held at the Richmond County Public Health Building.

The recent postgraduate course concerned with fractures in general practice held at the Medical College of Georgia in Augusta, was coordinated by FLOYD BLIVEN, of Augusta.

EXECUTIVE COMMITTEE OF COUNCIL MEETING MINUTES

THE NOVEMBER MEETING of the Medical Association of Georgia Executive Committee of Council was called to order by Chairman Milford B. Hatcher at 8:00 A.M., on November 5, 1960, at MAG Headquarters Building, Atlanta, Georgia.

Executive Committee members present included: Milford B. Hatcher, Macon, President; Fred H. Simonton, Chickamauga, President-Elect; J. G. McDaniel, Atlanta, Chairman of Council; John T. Mauldin, Atlanta, Secretary, and J. Frank Walker, Atlanta, Vice Speaker of the House. Also in attendance were Messrs. M. D. Krueger and John F. Kiser and Mrs. Catherine Wooten, of the MAG Headquarters Office Staff.

The invocation was a silent prayer requested by Chairman Hatcher.

The reading of the minutes of the last meeting was omitted because it was a special called meeting in October.

Training Meetings for Home Demonstration Agents

Mr. Krueger read a letter from Mrs. Lucile Higginbotham requesting that MAG representatives participate in these meetings, which are scheduled for February, April, and May, 1961. It was recommended that the Secretary write the president of each county society requesting him to designate someone to represent MAG at the meeting in his county. The president could be the representative or confer with the County Health Officer regarding representation at the meeting. The Secretary is also to write Mrs. Higginbotham giving her the names of the presidents of the county societies and including a statement that the Executive Committee of Council feels that this is important as regards such items as "home canning," etc.

Report on Kerr-Mills Bill Implementation

Secretary Mauldin gave a review and background information on possible plans of implementation for Georgia.

Political Action Activity

It was recommended by Secretary Mauldin that this be deferred until the next Executive Committee meeting.

AMA-MAG Alternate Delegates Expenses

Chairman Hatcher discussed the urgency of deciding on this question as soon as possible. On motion (Mauldin-McDaniel) it was voted to recommend to the Finance Committee that if

funds are available they be set aside for such purpose, but not to exceed one-half of the regular delegate's allowance.

Georgia State Nurses Association

Chairman Hatcher read a resolution sent him by the above organization, along with three other nurses groups, as being against any laws which would suggest any change in the nursing laws. It was recommended that Dr. Hatcher write a letter of acknowledgement of receipt of the letter.

American Physical Therapy Association

This was deferred until the December meeting.

Service Membership in MAG

This item was deferred until the December meeting.

Purchase of Machine for Headquarters Office

This was deferred until the December meeting.

Officers Listing Plaque

Mr. Krueger recommended that, with the approval of the Executive Committee, he and Dr. Mauldin would work out plans for the purchase of a plaque. On motion duly made and seconded, this was approved.

SAMA Letter of Appreciation

Mr. Krueger read a letter from the Georgia President of SAMA, Robert P. Taylor, thanking MAG for the donation for Region One meeting in October. This was received for information only.

Other Business

(1) *Funds for Andrew College*: Dr. Hatcher discussed request for a letter to MAG membership for purpose of raising funds for J. D. Patterson Dormitory at Andrew College, Cuthbert, Georgia. It was recommended that Dr. Woody put an insertion in the *Journal* publicizing this activity.

(2) *Venable Letter*: Dr. Hatcher discussed a letter from Dr. Venable of the State Health Department re: amendments on Mental Health laws (13 and 14). It was recommended and voted that MAG go on record as approving these amendments.

(3) *Date and site of December Executive Committee meeting*: It was recommended that this be decided by President Hatcher.

There being no further business the meeting was adjourned at 9:05 A.M.

STATE MEDICARE REVIEW BOARD MEETING MINUTES

THE ANNUAL MEETING of the State Medicare Review Board for Georgia was called to order by State Review Board Chairman W. Vernon Skiles at 2:00 P.M., November 13, 1960, at MAG Headquarters, Atlanta, Georgia.

Review board members present included W. Vernon Skiles, State Review Board Chairman; P. C. Shea, Jr., Co-chairman Atlanta Review Board; Joseph Hilsman, Co-chairman Atlanta Review Board; Lee H. Battle, Jr., Rome Review Board Chairman; Frank Thomas, Albany Review Board Chairman; M. M. Schneider, Appointee Savannah Review Board Chairman; E. R. Watson, representing Macon Review Board Chairman; J. B. Mercer, Appointee Brunswick Review Board Chairman; J. T. Mauldin, Secretary Medical Association of Georgia; Mrs. Jean Buice, Assistant Medicare Administrator, and Mr. Frantz Lipsey, Medicare Administrator.

There being no minutes from any previous State Review Board meetings, Dr. Skiles proceeded to call on Dr. Mauldin for a report on Medicare policies and administration.

Medicare Policies and Administration

Dr. Mauldin reported on the Medicare policies and administration, bringing out the points as to the purpose of the meeting which included:

1. To recommend policy for the Medicare program.

2. To recommend contract changes concerning the Medicare program.

3. To set up a convenient, workable board of review for Medicare special reports.

4. To foster better relationships between the Headquarters office and the doctors.

Administrative problems which Dr. Mauldin discussed were:

1. The fact that the \$4500.00 a year income aspect of adjudicating claims should be borne in mind by the local review board in adjudicating Medicare special reports.

2. All chairmen were urged to use the board system of adjudicating claims and having a specialist in the field, which the claims concerned, assist in the adjudication.

3. A request was made that all adjudications from local review boards of special reports be returned with a written adjudication in letter form so that records can be maintained on the review board decisions.

4. The fact that some review boards were delinquent in adjudicating and returning claims was brought out and it was urged that the local review boards be as prompt as possible in adjudicating and returning these claims so that payment may not be held up longer than necessary.

The discussion of policy concerning the Medicare program covered all points as follows:

1. The State Review Board is to be the primary point from which recommendations for policy changes are to begin.

2. All policy recommendations arrived at in the State Review Board meetings shall be passed on to the Council of the Medical Association of Georgia for approval.

3. All policy changes approved by the Council shall in turn be submitted to the Government for incorporation into the contract whenever necessary.

4. Changes in Medicare fees, allowable procedures, term of office for review board chairmen, and other special areas of the contract are questions for the State Review Board to consider.

5. The members of the State Review Board were informed that the Medicare Administrator has been authorized to travel to any area to discuss Medicare with any doctor or group of doctors wishing more information on the Medicare program.

6. Dr. Mauldin stressed the point that the Office for Dependents' Medical Care in Washington is making every effort to cooperate with the review board chairmen and with the doctors in the State.

Contract Renegotiation Discussion—Schedule of Maximum Allowances

Chairman Skiles called on Dr. Mercer for discussion on schedule of maximum allowances.

A motion was made by Dr. Schneider that a maximum allowance of \$3.00 be incorporated into the contract as payment for all parenteral drugs given by the physician which are deemed necessary for the proper management of the condition. This maximum fee is to be considered payment for the cost of the drugs, as well as the administration of said drug. The exception being unusual conditions requiring more expensive drugs. Motion was seconded by Dr. Mercer and passed unanimously.

Chairman Skiles recognized Dr. Mercer for discussion on the area concerning the 50 per cent allowance for new born care rendered by the delivering physician. Dr. Mercer stressed the point that doctors in his area felt that full payment for this procedure should be made regardless of whether the physician rendering the services was a pediatrician or the delivering phy-

sician. The basis for this suggestion was founded on the practical point that the same amount of time and care is rendered by the delivering physician, as by the pediatrician, for new born care. A motion was then made by Dr. Mercer that all physicians be paid the same allowance for hospital care of normal new born babies. The motion was seconded and carried unanimously.

Dr. Watson, representing the Macon pediatric group, recommended that changes be made in the procedure for billing for new born care. He brought out pertinent facts showing that his area used different methods in charging for new born care. He recommended that the Medicare contract be changed in regard to the billing procedures on new born care in the following manner:

A maximum amount of \$10.00 be paid for the first visit to the nursery and \$5.00 thereafter for each necessary visit.

Medicare Billing Practices

In the absence of Jule C. Neal, Jr., Chairman Skiles recognized Mr. Lipsey, Medicare Administrator, for a report on the Medicare billing practices. Mr. Lipsey stressed the point that an effort should be made by the review board chairmen to notify the doctors in their area that they must not bill the patient for the difference between their charges for the care rendered and the amount paid by Medicare.

Term of Office for Review Board Chairmen

Dr. Hilsman discussed the problem related to the indefinite term of office for review board chairmen. Dr. Thomas explained that the original setup for the chairmanship of the review board was that the chairmen appointed by the president of the district society was to appoint in turn members to serve on his board for adjudicating Medicare special reports. Dr. Thomas made a motion that there be a three man review board in each district, rotating yearly; one man added each year, the senior man to be chairman, two men recommended yearly by the review board, and one appointed to the review board by the district president. The motion was seconded and carried unanimously.

Report of Administrator

The Medicare Administrator reported on the present system of operations for Medicare and discussed problem areas facing Medicare and its administration.

New Business

Dr. Mercer made a motion that the Georgia State Medicare Review Board recommend to Washington that the present claim form be simplified and modified, if at all possible. Motion was seconded and carried unanimously.

Motion was made by Dr. Mercer that all claims not stating whether or not more than one physician was concerned with the case should be sent back to the physician for completion before payment. Motion was seconded and carried unanimously.

Dr. Thomas made the motion that an annual meeting of the State Medicare Review Board be held in the future and that any specially called meeting be held as necessary. Motion was seconded and carried unanimously.

Adjournment

Motion was made and seconded that the meeting be adjourned.

**Plan Now to Attend the
Annual Session
of the
Medical Association of Georgia**

May 7-10, 1961

Atlanta, Georgia

Mark These Dates on Your Calendar

MAY 7-10, 1961

These are the dates for the

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of the

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- Will it admit you to most hospitals?
- Does it cover most common hospital?
- Does it cover outpatient surgery, diagnostic and laboratory services, nursing home care, etc?
- Is enough for big medical and hospital expenses?
- Are cost-sharing in contract?
- Are you financially stable?

50107

DON'T ABUSE your
HEALTH INSURANCE
Use it only when you
need it. Don't feel
cheated if you're not ill!

The ? cost of
Medical Care..

...o new public service pub
cation for state

The Cost of Medical Care...

HIGH

Low

Some interesting facts everyone should know...

...in the last 20 years--
MEDICAL SCIENCE
has been making
SPECTACULAR
PROGRESS


A child born TODAY can expect to live 10 YEARS LONGER than one born 50 years ago.

ANTIBIOTIC
DRUGS prevent
PNEUMONIA
not used to
1 in every 3 or 4
ing it attacked

Tell me... what do I
buy when I pay for
"MEDICAL CARE"
...?

**YOUR
FAMILY
PHYSICIAN**

Average person sees doctor 3 times a year.



Today, doctors average 60 hours work each week -- see more patients, use improved techniques, equipment, drugs. Their fees have gone up much less than the average price of all other consumer goods and services.

SPECIALISTS
if needed

...plus 24 Hours-a-Day
HOSPITAL CARE

-- plus
new **Drugs**
antibiotics to
save your life

better
ABC

NEW EQUIPMENT
for improved
and safer
diagnosis
and treatment

Two or more hospital employees
per patient -- special equipment
-- room and meals -- laundry.
Accredited hospitals must
meet new high standards.

Accredited hospitals must meet new high standards.

TODAY -- more and better health care are available. "Medical Care" covers health restoring services that exist **20 years ago!**

MEDICAL CARE

HOSPITALS GET MORE
mainly because so much
of hospital costs are in
the form of (their).

There are 2 employees
per patient on the staff
...and payrolls are
65-75% in 20 years

128 million people
are now covered
health insurance

Yes--but--aren't my health bills HIGHER than there used to be?

...in terms of
INFLATED DOLLARS--
yes, like everything else... but
let's compare the PERCENTAGE
of increase in the prices of
some things today with
20 years ago!

Actually... Doctors' Fees
haven't risen as much as
other prices.

**TODAY'S
PRICES**
compared
with
**20 years
ago...**

... used in this building
... in 1929 and ...

NOTE: ...
available ...



Where today's dollar goes:

CONSUMER DOLLAR

hmmmm...
so today I'm spending
only **6¢** of my dollar
for **HEALTH!**

Mr. Average
American

See page 72

You, your doctor and the economic freedoms |

WHY WE ALL SHOULD BE CONCERNED
ABOUT PRESERVING FREE CHOICE IN
ECONOMICS AS WELL AS IN POLITICS

YOU MAY WONDER what the statement on the opposite page has to do with doctors and medicine. After all, we are medical men — not businessmen. So why have we chosen to reprint a document proclaiming freedoms which, on the surface at least, apply primarily to commerce and industry?

The fact is that this proclamation of economic freedoms is vitally important to us all — whether we be physicians or farmers, whether we work in a factory or teach in a school, whether we practice the law or clerk in a store. Altogether, the points stated at right have as much bearing on our way of life as the ideas expressed in the Declaration of Independence, the Constitution, the Bill of Rights.

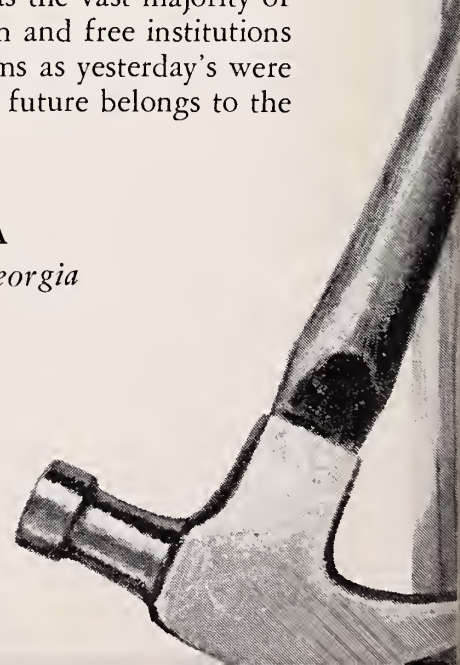
IN AMERICA, we have what amounts to a secular religion — one subscribed to with equal fervor by people of all denominations. It is the faith in freedom, in self-government, in democracy. It is the faith that creates a climate for accomplishment — in medicine, as in all fields of endeavor.

History has proved the validity of this faith — the ability of free men to find the right answers to problems, both large and small . . . to make the many small gains which eventually add up to great advances.

WE MUST CONTINUE TO BELIEVE, as the vast majority of Americans have always believed, that free men and free institutions can face up to, and solve, tomorrow's problems as yesterday's were solved. We must continue to believe that the future belongs to the free — in every aspect of living.

MEDICAL ASSOCIATION OF GEORGIA

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Cover:

American Medical Association's new booklet "The Cost of Medical Care" is enclosed with this issue and is available in small quantities on request to the Medical Association of Georgia.

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PILONIDAL CYST — MISNAMED, MISUNDERSTOOD, AND MISTREATED

Robert M. Hardaway, Col., M.C., *Washington, D. C.*

The sinus is not congenital, but develops when hair punctures the skin of the internatal cleft.

PILONIDAL DISEASE IS apparently much more common in the military service than in civilian life. This is probably because (a) pilonidal sinus is a disease primarily of young men, and (b) conditions of military life are conducive to the start of symptoms. A total of 77,637 soldiers were admitted to Army hospitals for pilonidal disease during the war years of 1942 through 1945; they remained an average of 44 days. This is the equivalent of six infantry divisions out of combat for one and one-half months. These figures do not include 9,000 other cases of pilonidal cyst admitted primarily for other disease or hundreds of thousands of out-patient visits.¹

Prior to World War II, the accepted treatment for pilonidal disease in the Army was excision and this persists in civilian practice today. The Army, however, has come to accept a much more conservative treatment.² This was dictated by the sum of many experiences like my own. I performed 144 excisions of symptomatic pilonidal sinus in 17 months prior to World War II, with primary healing in more than 90 per cent. The results seemed good at the time and appeared to warrant excision of controlled, but previously symptomatic, pilonidal disease.

However, during subsequent years, follow-up on these patients with "good" results showed that many of them had had recurrent trouble since the

first operation. (These patients showed the same small, round midline openings which nonsurgical patients show. Certainly these skin openings were removed at the first operation, which was a wide-block excision. These openings were definitely not congenital.)

Similar results were experienced by the Army as a whole. Although initial results in most properly prepared patients were good, a large proportion had further trouble later. It was not uncommon to see large numbers of patients with pilonidal disease occupying many hospital beds for long periods of time and performing little or no military duty during their entire Army career. A large proportion gave a history of previous excision, most of which were of the wide-block type. What was wrong? Careful operation seemed completely to excise the "cyst" and its chronically infected, granulation-tissue-lined sinus tracts, but still "recurrences" were common. No method of excision seemed to prevent them, although the types of operation for pilonidal cyst were almost as numerous as the number of surgeons performing them. Attempts to obliterate dead space, preserve normal issue, cover the sacrum with fat-padded skin, eliminate buried suture material, and other good surgical principles, seemed to have no dramatic effect. It was said that recurrences were due to inadequate excision of the epithelium of the cyst.³

In 1946 the first of a series of papers⁴⁻¹⁰ appeared showing that a hair, when introduced into a skin cleft which is constantly in motion (i.e., between the fingers), could erode through the skin and form

¹Presented at the *106th Annual Session of the Medical Association of Georgia, May 3, 1960, Columbus, Georgia.

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a sinus tract, which would remain open as a result of the constant foreign-body reaction of the hair. Some of these sinus tracts were lined by squamous epithelium which simulated a hair follicle. (Hair follicles do not normally occur between the fingers.) The postulation was made that hair in the intergluteal cleft could be sucked into the opening of a "pilonidal cyst" by the constant compression and decompression of riding in a jeep or other vehicle.⁹ This brought to mind the fact that while hair is seen protruding from, or rolled up in, most "pilonidal cysts," it always lifts out easily. The hair is free at both ends. While hair is so frequently present in the tract, hair follicles, numerous in the surrounding skin, are rarely seen in the sinus tract, and when they are seen, the hair is frequently degenerating. None of these "follicles" show accessory glands or a cup-shaped "root" at the bottom. One wonders whether these are real follicles or are small tracts along the hair into which epithelium has grown (Figures 1, 2, and 3).

Infected Pilonidal

Infected pilonidal cysts are often seen in hairy persons with deep intergluteal clefts soon after puberty. Pilonidal sinuses may occur in the perineal region, between the toes, and in the axilla.¹¹⁻¹³ I have seen two pilonidal sinuses of the umbilicus¹⁷ (Figure 4).

All this seems to point to the fact that hairs seen protruding from a "pilonidal cyst" are sticking in and not out. In fact, skin hair may frequently be seen dripping over into the sinus opening. The time (after puberty) of initial infection of the tract and

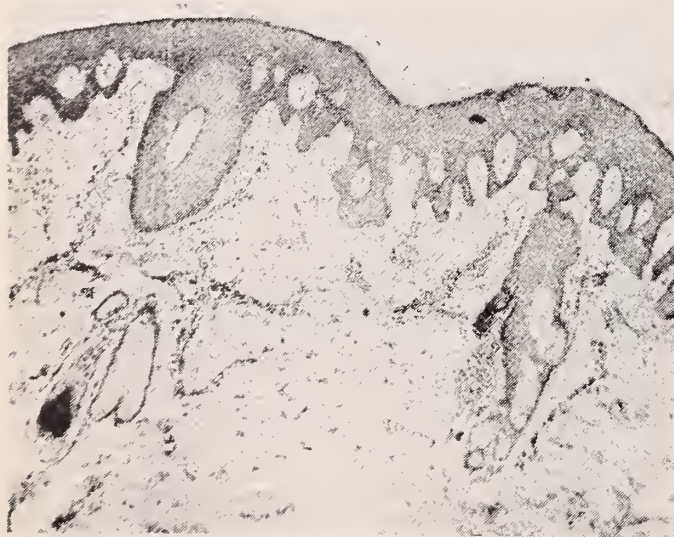


Figure 1: Section of skin near the orifice of a pilonidal sinus. Note the close spacing of the hair follicles and the cup-shaped root at the bottom of one of the follicles. The follicles are roughly perpendicular to the skin surface and sebaceous glands are present. Note that the hair shaft is in good condition.



Figure 2: Pilonidal sinus with no epithelium. Note hairs in the cavity of the sinus. Epithelium may grow into this sinus around the hair. This tract quickly heals when the hair is removed.

the frequent "recurrence" after adequate excision point to ingrowing hair as a major problem. Given a perfectly normal person with no sinus opening, it is known that poor personal hygiene, sweat, and irritation will produce a painful, tender inflammation with weeping and excoriation in the intergluteal fold. Oriental males seldom have pilonidal disease and have very little hair in the sacral area. The disease is, therefore, not congenital, but develops when hair punctures the skin of the internatal cleft and epithelium grows inward along the tract occupied by the hair.^{4,14,15} The congenital anal dimple, present in many persons, is not an embryonic remnant of the neural-tube invagination.¹⁶ Like any other dimple, it is due to the attachment of the skin to underlying bone or fascia by fibrous strands. It may form a small superficial pocket, which traps

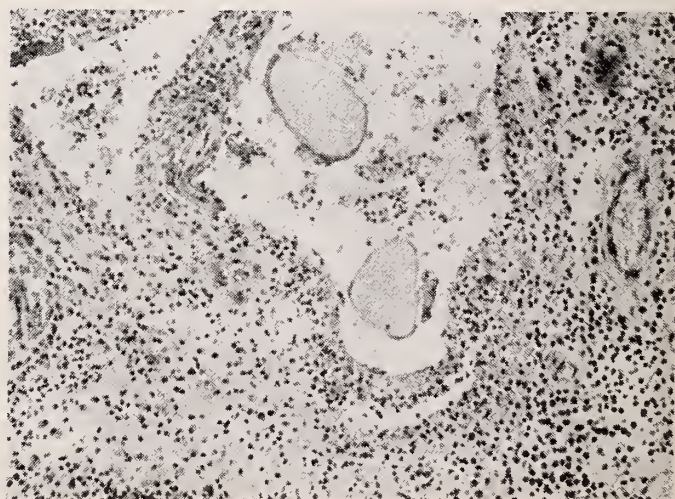


Figure 3: Section through a pilonidal sinus. One of the rather rare hair "follicles" is seen. Note that the follicle is not of the usual appearance and appears to run parallel to the epithelium lining the sinus. No cup-shaped root was identified in the sections. Although the epithelium is thriving, the hair in the center is dead and degenerating. No sebaceous glands, normally associated with hair follicles, can be found. This is probably a sinus tract around a foreign-body hair into which squamous epithelium has grown.



Figure 4: Umbilicus showing sinus opening previously occupied by a bundle of hair.

hair and debris in the manner described above. The umbilicus may act in a similar way as we have seen. Oddly enough, this very concept was stated by Hodges¹⁸ in 1880 when he first described and named pilonidal sinus.

Once infection has started, it burrows in much the same fashion as a fistula in ano or hidradenitis suppurative. In fact, these two conditions are sometimes difficult to differentiate from an infected pilonidal sinus.

Regimen Recommended by Military Service

With these facts in mind, the following regimen is recommended for managing cases of pilonidal disease in the military service:

1. The entire intergluteal area is shaved (every four to five days) whenever infection is present or threatens, especially in summer, on field problems, etc. All hair is removed from the sinus opening and kept out.
2. Meticulous personal hygiene is observed, with thorough soap-and-water cleansing of the intergluteal area daily. Hexachlorophene detergent should be used, if possible. After a bowel movement the anal area is cleaned, with movement away from the intergluteal area, not toward it. The area is kept as dry as possible. Weight reduction is advised in the obese person and upright sitting with no slouching on the sacrum.
3. A permanent profile is adopted, stipulating that the patient not be assigned as a driver or routine passenger in a vehicle (military police duty, etc.).
4. If there is an abscess, the patient is hospitalized and the abscess drained. No antibiotics are ever indicated.
5. If there is a chronic draining sinus unresponsive to the above treatment, the patient is hospitalized and the tract laid open. Hair and debris (occasionally toilet paper), which are nearly always found in the tract, are wiped away. Ordinarily, no

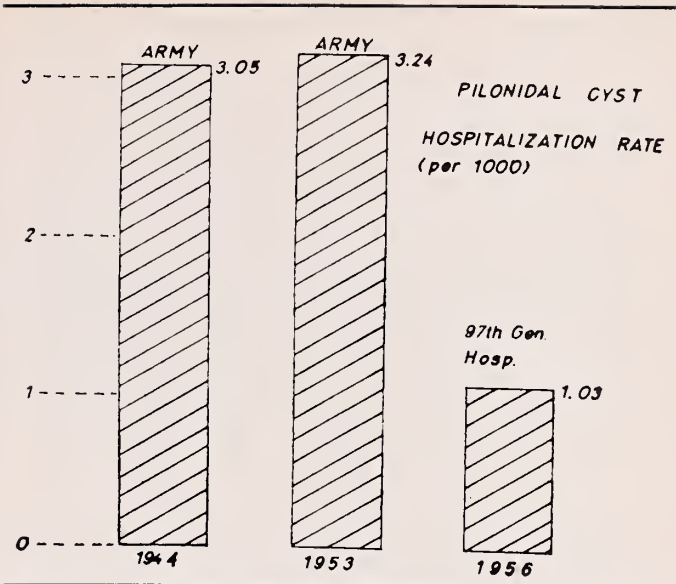


Figure 5: Hospitalization rate for pilonidal cyst in the U.S. Army for the years 1944 and 1953, and at the 97th General Hospital in the year 1956. The conservative treatment recommended by the Army after World War II has not affected the hospitalization rate. However, treatment presently used cuts hospital admission rate by two-thirds.

tissue is excised and no sutures are used. Occasionally epithelium at the mouth of the tract is wiped off with a sponge. Healing is rapid. Other patients are not hospitalized. In civilian practice few patients should need hospitalization.

Excisional surgery is not necessary. As a matter of fact, the only difficult cases to control are those patients who have had a previous excision (Figures 5 and 6). Both the hospital admission rate and

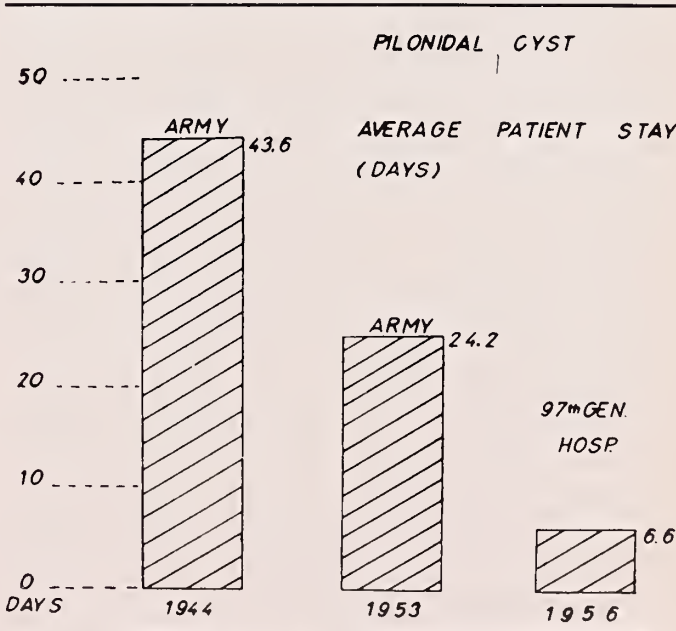


Figure 6: Average duration of patient stay in the hospital for pilonidal cysts for the years 1944, 1953, and 1956. The first two columns are Army-wide figures; the third pertains to the 97th General Hospital only. The drop from 43.6 to 24.2 is the result of conservative policy recommended by the Army following World War II. A further reduction at the 97th General Hospital reflects a further decrease in average patient stay as a result of the treatment described in the present article.

PILONIDAL CYST / Hardaway

length of hospitalization have been markedly reduced.

Summary and Conclusions

"Pilonidal cyst" is not a cyst, but is an acquired intergluteal sinus secondary to ingrown hair from the intergluteal skin with added infection and granuloma or abscess. "Recurrence" and infection are usually due to ingrown hair, trauma, and poor personal hygiene. Treatment is best carried out by removal of hair and not by excision.

Walter Reed Army Medical Center

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DEBATES ON COMPULSORY HEALTH INSURANCE

THE THREE MOST OFTEN repeated words on college campuses throughout the country this year will be: *Compulsory Health Insurance*.

More than 5,000 college and university students, taking part in the 1960-61 National Intercollegiate Debate program, are currently discussing the proposition: That the United States should adopt a program of compulsory health insurance for all citizens.

The discussion question was chosen through an annual poll of debating coaches throughout the country by the Committee on Intercollegiate Discussion and Debate of the Speech Association of America. Each student engaged in the intercollegiate debate must learn both sides of the question.

Colleges and universities are now holding intra-school elimination contests. From there, invitational debates will be held among schools on a regional basis.

A highlight of the year's debating activity will take place next Spring at the United States Military Academy, West Point, N. Y., at which meeting regional forensic champions from leading universities will compete in the national spotlight.

Because the evolution of health insurance has so important a bearing on the intercollegiate debating topic, the Health Insurance Institute developed an insurance reference kit specifically for this purpose. Nearly 4,000 of these kits were sent to colleges and universities before the opening of the school year for use by debaters, speech departments, and libraries. The Institute has be-

come the central source of insurance information on the debating topic and has made its services available to students for further research.

Insurance reference kits have been requested by many national organizations interested in the national debate program. Such requests have come from the National Association of Manufacturers, the American Institute of Banking, the American Association of University Teachers of Insurance, and numerous hospital and medical societies. To date, the Institute has distributed a total of over 8,000 kits to all sources and requests are still coming in at a rapid rate.

As a further aid to debaters in defining special areas of the discussion question, the Health Insurance Institute in December released a Supplementary Insurance Reference Kit. The supplementary kit includes:

1. A "Fact File" for use by debaters. This file gives a comprehensive outline of the provisions and financing of medical care in the United States and other countries. It contains cost and spending comparisons on medical care in England, France, Italy, the United States, and West Germany.

2. Two debate presentations giving the negative side of the question. These presentations, previously tested at leading Eastern and Midwestern universities, define the terminology of the resolution, give the historic background of the question, and discuss the relationships of government with labor, industry, and medicine within the framework of the free enterprise system.

EMPHYSEMATOUS GASTRITIS AND SPONTANEOUS TENSION PNEUMOPERITONEUM

A previously unreported cause for a rare gastrointestinal syndrome.

Arthur M. Knight, M.D., *Waycross*

THE FOLLOWING IS BELIEVED to be the seventh reported case of emphysematous gastritis. The etiology in this case is different from that of any previously reported case. This case also illustrates a previously unreported cause for free intraperitoneal gas under tension. It illustrates the danger of Levin tube intubation of the stomach in patients with pulmonary emphysema. It also indicates that "not all distention is ileus."

Fraenkel first described "emphysematous gastritis" in 1889.¹ By this term he meant to designate a phlegmonous gastritis caused by gas forming organisms. Only four cases had appeared in the literature by 1952. In that year Henry² reported a fifth case in a one-month-old white male infant. In 1957 Plachta and Speer reported a case³ of non-bacterial gastric emphysema which was very similar to the present case, though their case showed no gastritis and no tension pneumoperitoneum.

There have been several good reviews of the causes of free intraperitoneal air in the abdomen.^{4,5} In none of the cases discussed was the cause for spontaneous pneumoperitoneum precisely the same as in the case presented here.

Case Report

I.I.A. was a 76-year-old, colored, retired, married male who became ill on May 8, 1960. He had previously enjoyed excellent health and had not consulted a physician in 47 years. The presenting complaint was nausea and vomiting. He vomited for 48 hours before coming to the hospital and the vomitus eventually became chocolate colored. He complained also of abdominal pain and swelling. There

was no history of addiction to alcohol. He had had no gastrointestinal symptoms for many years and stated that he had never coughed or been short of breath. There was no history of bronchial asthma and there had been no loss of weight over the previous year.

Temperature at time of admission was 99° F. by mouth. Pulse was 90, respiratory rate 20, and blood pressure 100/80. The chest was somewhat emphysematous and heart and breath sounds were distant. There was a marked ballooning out of the entire upper abdomen. This was more prominent in the left upper quadrant. No mass could be felt and there was no localized area of tenderness. The patient was thought to be suffering from pyloric obstruction secondary to peptic ulceration or carcinoma.

Laboratory data at the time of admission revealed that the urine had a specific gravity of 1.020 with ++++ albumin and four to six white blood cells per high power field, as well as rare red blood cells. There were also a few finely granular casts present. The red blood count was 7.42 million with 8 gms. of hemoglobin. The white blood count was 18,450 with 87 per cent polymorphonuclear leukocytes and 37 per cent lymphocytes.

Shortly after admission the patient was intubated with a Levin tube connected to a gastric suction device. He was supported with intravenous fluids and given meperidine when needed for pain. By the night of May 16th the abdomen was flat and soft and the patient's general condition appeared to be good. The Levin tube was removed and he was started on oral feedings. Because surgery was planned for May 20th, the Levin tube was rein-

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serted on May 19th. At 6:00 P.M. on May 19th the patient had an attack in which he felt cold and clammy. At this time his pulse was weak and his abdomen quite distended. At 8:00 P.M. on the 19th he suddenly expired. It was found that the Levin tube was not decompressing the abdomen because it contained blood and blood clots. These had not been present at 6:00 P.M. when the tube was last irrigated.

At autopsy the body was that of a poorly nourished, fairly well developed colored male of approximately 76 years of age. He was somewhat wasted, suggesting recent weight loss. The mucous membranes were extremely pale. The abdomen was greatly distended with gas. This distention was so pronounced that there was marked bulging at both inguinal rings. When the abdominal cavity was opened, a tremendous amount of free gas escaped through the incision. The pronounced abdominal distention immediately disappeared. The abdominal cavity contained two to three liters of bloody, brownish fluid which had a sweetish odor. The stomach was greatly dilated, being several times normal size

and appearing dark purple and almost gangrenous throughout. A perforation was present in the gangrenous area. The gastric mucosa appeared acutely inflamed and hemorrhagic. Almost the entire lesser curvature of the stomach was gangrenous. There was no obstruction to the gastric outlet. Distal to the stomach, there was no dilatation or distention of any portion of the gastrointestinal tract. The most striking things about these portions was the pronounced emphysema of the mesentery and of the coats of the wall of the intestine. Numerous small emphysematous blebs could be seen in the serosa, especially in the region of the sigmoid colon.

The summary of gross pathological findings was recorded as follows: (1) left ventricular hypertrophy; (2) atherosclerosis and dilatation of the thoracic aorta; (3) pulmonary emphysema (Figure 1); (4) gastritis, gangrenous, and hemorrhagic (Figure 2); (5) gastric perforation; (6) hemorrhage, gastrointestinal, massive; (7) peritonitis, generalized, chemical, and hemorrhagic; (8) emphysema, interstitial, esophagus, mesentery, sigmoid colon (Figures 3, 4, and 5); (9) nephrosclerosis; (10) ascites, due to gastric juice, blood, and inflammatory exudate, and (11) tension pneumoperitoneum.

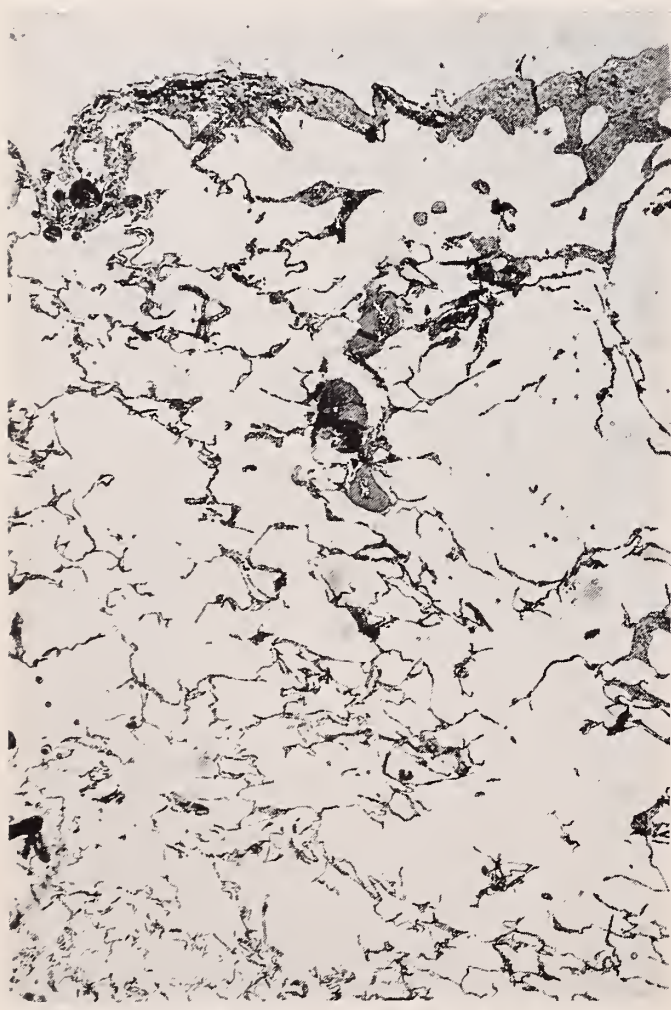


Figure 1: Obstructive emphysema with rupture of alveoli.



Figure 2: Low power view of gastric mucosa.



Figure 3: Wall of esophagus showing emphysema of serosa at site of adhesions to right lung.



Figure 4: Low power view of esophageal mucosa and muscularis showing inflammation and emphysema.

The summary of microscopic anatomic findings was recorded as follows: (1) hypertrophy of myocardial fibers; (2) obstructive pulmonary emphysema (Figure 1); (3) interstitial pulmonary emphysema (Figures 1 and 3); (4) esophagitis, acute (Figure 4); (5) gastritis, acute (Figure 6); (6) necrosis of areas of gastric mucosa (Figure 2); (7) gastric hemorrhage, resulting from above; (8) gastric perforation; (9) emphysema, interstitial, lower one-third of the esophagus (Figure 5), and (10) emphysema, interstitial, mesentery, and serosa of the intestinal tract.

Discussion

This patient had a nasogastric tube in his esophagus and stomach throughout most of his hospital stay. He had chronic obstructive pulmonary emphysema. There were inflammatory changes in the esophagus and stomach. It was theorized that the tube in the esophagus had indented the trachea sufficiently to increase the degree of obstruction to outflow of air. This was thought to have been responsible for the rupture of air into the interstitial spaces of the lung. There were adhesions between the right lung and the lower esophagus (Figure 3). The interstitial emphysema of the lung appears to have dissected

into the esophagus and along the gastrointestinal tract with accumulation of air under the serosal coat of the gastrointestinal tract. It is also possible that air embolization occurred. It is probable that air escaping through the serosa into the peritoneal cavity is what caused the marked abdominal distention (tension pneumoperitoneum). The marked dilatation of the stomach was undoubtedly due to atonia.

The remainder of the gastrointestinal tract was collapsed. Microscopic sections through the gastric mucosa and through the esophagus showed many bacteria (Figure 6). These organisms appeared to have been cocci and were probably not gas producers.

This case illustrates interstitial emphysema of the lung with dissection along the vessels into the abdominal viscera. Death was considered to be due to toxemia, anoxia, hemorrhage, shock, and heart failure.

Summary

A case of emphysematous gastritis is presented. This case demonstrates emphysema of the lower esophagus and of the subserosal layer of practically the entire gastrointestinal tract. Spontaneous tension



Figure 5: Dissection of air between muscle layers of esophagus.

pneumoperitoneum was also present. The patient had obstructive pulmonary emphysema. There were adhesions between the right lung and the esophagus. The acute illnesses began with nausea and vomiting of digested blood. Therapy included intubation with a Levin tube. This tube increased the expiratory pressure in the lung by indenting the posterior wall of the trachea. Emphysematous blebs in the lung appear to have ruptured and air to have dissected into the esophagus. Air escaped into the free peritoneal cavity producing tension pneumoperitoneum. Although a bacterial gastritis was present, there was

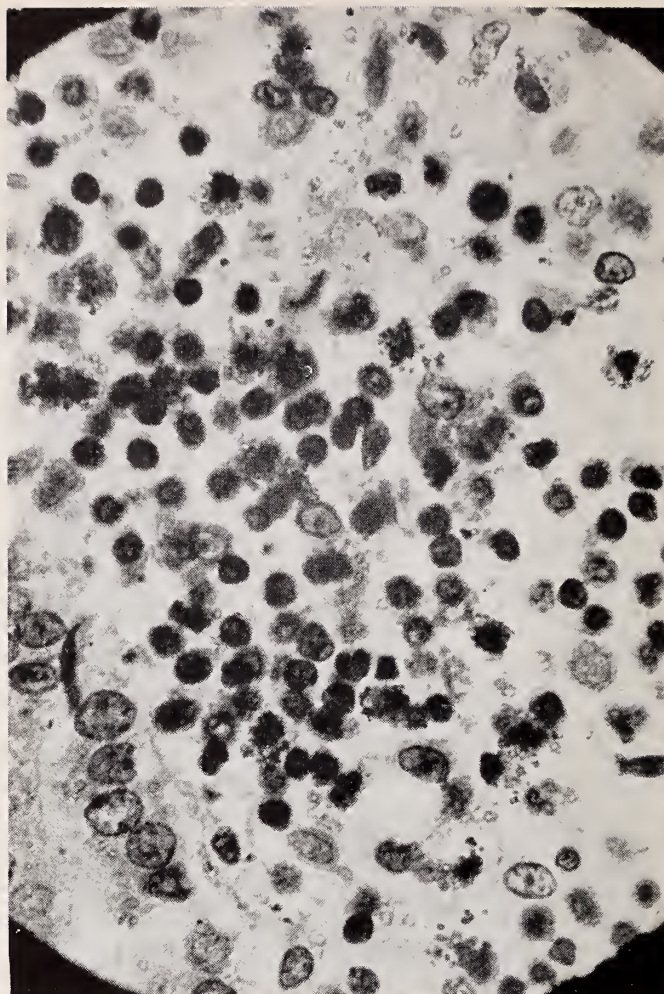


Figure 6: High power view of gastric exudate showing bacteria.

no evidence that it was caused by gas-producing organisms.

P.O. Box 899

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J. C. PATTERSON HALL UNDER CONSTRUCTION

THE ANDREW COLLEGE at Cuthbert is building a new dormitory that will be named the "J. C. Patterson Hall" in memory of the late Dr. J. C. Patterson of Cuthbert.

Dr. Patterson was president of the Medical Association of Georgia for the year 1940-41 and was very

active in the Association for many years. He was also a Trustee of Andrew College for a number of years.

A fund has been set up for this dormitory and any contribution will be appreciated. Address your contributions to Andrew College, Cuthbert, Ga.

OPERATIVE CHOLANGIOGRAPHY

Harold S. Engler, M.D.; Thomas C. Mann, M.D.; Edwin L. Brackney, M.D., and
William H. Moretz, M.D., *Augusta*

Forty-one common duct explorations were safely omitted by the use of this valuable adjunct.

SHOULD CHOLANGIOGRAMS BE obtained routinely during operations for diseases of the biliary tract? How often does such an "operative cholangiogram" alter the surgical procedure indicated? Does a normal cholangiogram rule out the need for exploring the common duct if exploration is otherwise indicated? Is the added time required for routine operative cholangiograms justified in those with indications already present for exploring the duct, or in those with no indication for exploring the duct?

These questions and others are heard frequently when operative cholangiography is being discussed. As the Eugene Talmadge Memorial Hospital was being opened, the policy was adopted of routine cholangiography in all operations for diseases of the biliary tract. The present study is an analysis of our experience with operative cholangiography in the Eugene Talmadge Memorial Hospital between its opening in June, 1956 and February, 1960.

Methods and Materials

During this period, 139 patients undergoing biliary tract surgery had operative cholangiograms (Table I). "Pre-exploration" operative cholangiograms, those made prior to dissecting or opening the common duct, were performed in 126 patients. "Post-exploration" operative cholangiograms, those made

through the T-tube after the duct was explored, but with the abdomen still open, were performed in 55 cases. Each patient in whom a "post-exploration" operative cholangiogram was performed had also one or more "follow-up" cholangiograms during his convalescent and postoperative period. Operative cholangiograms could not be done in some patients (biliary atresia) and was not done in others where it did not seem indicated (liver biopsy, carcinoma of the head of the pancreas, and acute cholecystitis.) Excluding such patients as these, operative cholangiography was routine except in six cases in whom it was omitted for various reasons.

Technique

Initially, before the patient is prepared and draped, the x-ray film is positioned and a scout film is taken to be sure of position and radiographic technique. After exposing the cystic duct, the duct is ligated at its junction with the gall bladder. A small polyethylene catheter is inserted through a transverse incision in the cystic duct on into the common duct. A ligature is placed about the cystic duct stabilizing the catheter and preventing extravasation about the catheter when the radiopaque agent is injected. Care must be taken not to insert the catheter through the common duct into the duodenum, for if this is done only a picture of the duodenal mucosa will result. All instruments are removed from the operative field. Seven or 8 cc. of 50 per cent Hypaque® are used for the injection, and with the patient's breathing controlled by the anesthetist, the x-ray is made. While the films are being developed, the gall bladder is dissected free. If the cystic duct is occluded or must be preserved with the gall bladder for side-tracking purposes, direct injection into the common duct is quite satisfactory. The developed x-ray film is returned to the operating room where it is interpreted by the surgeon. Whenever there is any question in the surgeon's mind as to the interpretation of the films, and if the radiologist has not already seen the films, the radiologist's opinion is obtained at that time. For

TABLE I

Patients with Operative Cholangiograms	139
Pre-exploration (63 common ducts explored)	126
Post-exploration	55
Patients with Follow-up Cholangiograms	56

From the Department of Surgery, Medical College of Georgia and the Eugene Talmadge Memorial Hospital, Augusta, Georgia.

*Presented at the *106th Annual Session of the Medical Association of Georgia, May 3, 1960, Columbus, Georgia.*

TABLE II
Results of Pre-Exploration Cholangiograms

Duct exploration clinically indicated	101
Cholangiograms in	88
Negative (False 2)	44
Positive (False 6)	39
Unsatisfactory	5

greatest usefulness, consultation with the radiologist should be routine.

If common duct exploration is carried out, a post-exploration cholangiogram is made through the T-tube prior to closing the abdomen.

Technical failure may result from the catheter reaching the duodenum, leakage of media from the cystic duct, motion or poor positioning of the patient or from poor x-ray technique. The frequent use of a standardized technique will increase familiarity with the procedure and prevent many of these failures. In this series, five pre-exploration and one post-exploration cholangiogram were unsatisfactory (Figures 1 and 2).

Results

The results of the pre-exploration cholangiograms (Table II) are considered in two groups. The first group is comprised of those who had clinical indications for exploring the common duct and the second group consists of those without such indications.

In the first group with indication for common duct exploration, there were 101 patients, of whom 88 had pre-exploration cholangiograms. Forty-four of these cholangiograms were interpreted to be negative. However, two of this group were false negatives. One of these negatives failed to show a three mm./d stone which was found on exploring the duct and

was removed. The other represented a carcinoma of the proximal common hepatic duct which was missed by the surgeon, but seen by the radiologist and later confirmed at autopsy. Thirty-nine of the 88 pre-exploration operative cholangiograms were interpreted as being positive. Six of these were probably false positives, in that no pathology was found on exploration. The 33 true positives represented 21 with stones, five with dilated ducts, three with stenosis of the sphincter of Oddi, and one each with biliary atresia, carcinoma of the pancreas, carcinoma of the ampulla of Vater, and sclerosing fibrosis of the common hepatic duct. The six false positives included four suggestive of stone, one partial obstruction of the common hepatic duct, and one "irregularity" of the distal common duct which is still unexplained. There were five unsatisfactory cholangiograms in this group of 88.

In the second group, without indications for duct exploration, 38 had pre-exploration cholangiograms, of which 35 were true negatives and three were interpreted to be positive (Table III). However, of the three positive cholangiograms in this group, only one was a true positive, two being without stones on exploration.

The relationship between proven stones and the pre-exploration cholangiograms is given in Table IV.

TABLE III
Results of Pre-Exploration Cholangiograms

Duct exploration not clinically indicated	38
Cholangiograms in	38
Negative (No False negatives)	35
Positive (2 False positives)	3

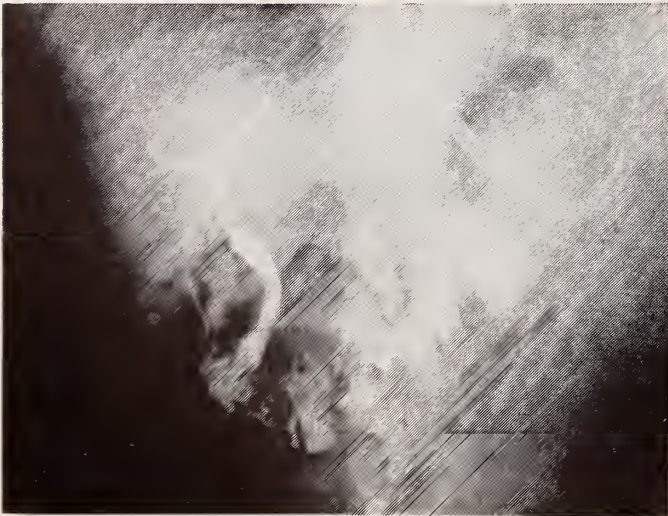


Figure 1: Pre-exploration operative cholangiogram showing a normal ductal system without stones or dilatation and with free egress of the dye into the duodenum. There are radiopaque stones in the gall bladder.



Figure 2: Pre-exploration cholangiogram showing dilatation of the entire ductal system and a large stone in the distal common duct obstructing the outflow of the dye into the duodenum.

TABLE IV
Correlation Between Proven C.D. Stones and
Pre-Exploration Cholangiograms

Patients with proven C.D. stones	23
True Positives	22
False Negatives	1
Cholangiograms interpreted falsely as showing stones	6

Twenty-two of the 23 patients with proven stones had stones revealed by the cholangiograms. In only one the stone did not show on the cholangiogram (false negative).

Of the 55 post-exploration cholangiograms (Table V), 53 were negative, (two false negative and three

TABLE V
Post Exploration Operative Cholangiograms

Common Duct Exploration For Any Reason (Ducts found to contain stones—23)	63
Post Exploration Cholangiograms (Unsatisfactory—1)	55
Negative for Residual stones (False Negative—2) (Inconclusive—3)	53
Positive for Residual stones	1

inconclusive), one unsatisfactory, and one was positive for residual stone in an intrahepatic duct. This intrahepatic stone was in too small and inaccessible a duct to be reached operatively, but subsequent follow-up films indicated that it had passed into the duodenum. The three "inconclusive" cholangiograms were interpreted as negative, but subsequent follow-up films showed "questionable" stones. However, the T-tubes have been removed from each of these three patients and none is having symptoms. Of the two false negative instances, one on repeated follow-up cholangiogram has a definite stone and the other died on his sixth post-operative day of acute pancreatitis, the stone being found in the common duct above the T-tube at post-mortem examination.

Follow-up cholangiograms, via T-tube, were made on one or more occasions in 56 patients whose common ducts were explored. Definite residual stones were revealed in three patients and residual stones were questioned in three others. However, in each instance of questionable stone, repeat cholangiograms have failed to substantiate the suspicion, and removal of the T-tube has not been followed by suggestive symptoms. Of the three definite residual stones, one was proven at autopsy (acute pancreatitis) and the other two were repeatedly seen on follow-up cholangiography (Figures 3 and 4).

Discussion

In each instance of biliary tract surgery, a decision must be made as to whether or not to explore the common duct. There is no general agreement as to the indications for common duct exploration, as evidenced by the differences of opinion found in the leading textbooks of surgery. The indications



Figure 3: Pre-exploration cholangiogram showing numerous calculi in the common, common hepatic, and right hepatic ducts. There are radiopaque calculi in the gall bladder.

for common duct exploration are necessarily favored by the previous experience of the operating surgeon. Those adopted for this study are as outlined by Lahey⁴ and others: (1) present jaundice or a history of jaundice, (2) thickening and dilation of the common duct, (3) small stones in the gall bladder or in the cystic duct, (4) palpable or questionably palpable common duct stones, (5) thickened and



Figure 4: Pre-exploration cholangiogram showing no stones but obstruction in the region of the distal common duct due to extrinsic pressure from carcinoma of the head of the pancreas.

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contracted gall bladder, or (6) the presence of muddy bile in the ducts.

It has been estimated that approximately 50 per cent of all common duct explorations performed are unnecessary.⁸ In this series the unusually high incidence of those in whom common duct exploration was indicated (101 of the 139 patients) can be related in part to the degree of selection of patients admitted to the Talmadge Hospital and in part to the adoption of broad indications for the procedure.

"Small stones" and thickened, contracted gall bladder" may be questioned as true indications for duct exploration. In this series, 27 patients had exploration indicated on these bases alone and in 23 of these the only indication was the presence of small stones. Pre-exploration operative cholangiograms in these 27 instances gave very valuable information in that 26 showed no stone and were true negatives and one was a true positive. These findings illustrate well one virtue of the pre-exploration operative cholangiogram. A normal cholangiogram gives the surgeon greater security in not exploring those ducts in which the indications for exploration are debatable. In this manner, it reduces the number of negative common duct explorations and thereby avoids for those particular patients the substantially increased morbidity and mortality of duct exploration.^{2,3,5} Three explorations were carried out in this group of 27, one for a true positive cholangiogram in which a stone was found and two because of relatively unsatisfactory x-rays in which no stones were found. Therefore, one can credit pre-exploration cholangiography with having obviated the need for 24 useless common duct explorations in these 27 patients.

The positive cholangiograms with stones were of value in showing the number and position of the stones. For instance, demonstrating stones within the intrahepatic ducts leads the surgeon to more thoroughly explore that area. Similarly, knowing a stone to be present in the distal duct, the surgeon is less likely to be satisfied short of actually removing the stone. Certain information is provided which can not easily be obtained by other means. The anomalous course of the distal duct is seen and exploration thereby made more safe. Added information is provided in the case of sclerosing fibrosis and with an early carcinoma of the ampulla or distal common duct. The pattern of the intrahepatic ducts revealed in this manner may subsequently prove of value in evaluating liver masses and diseases.

Of the 38 pre-exploratory operative cholangiograms in those without other indication for duct exploration, one was positive. In considering routine

operative cholangiograms in those without some indication for duct exploration, one might question whether it is wise to perform 38 procedures in order to find one additional stone-containing duct. Similar low yields have been cited by some as an argument against routine operative cholangiography. The answer to this depends to some extent upon the morbidity of operative cholangiography in such instances, which in this series is not appreciable.

Reliability of Pre-exploration Cholangiogram

The reliability of the pre-exploration cholangiogram in finding stones in the common duct is indicated by the 23 cases of proven common duct stones. There were 22 of these cases that had positive cholangiograms for stones. These stones varied in size of course, the larger ones being more easily diagnosed. It is inevitable that with very small stones the opaque media will, in some instances, not be displaced enough by the stone to show a radiolucency. This apparently was the case in our one false negative cholangiogram.

Post-exploration Operative Cholangiograms

Among the post-exploration operative cholangiograms in this series, in no instance was a residual stone seen at the time, with the exception of one small intrahepatic stone which could not be reached. In one instance, however, review of the films by the radiologist lead him to suspect a retained stone which was later proven to be present. This again points out the advisability of consultation with the radiologist at the time of cholangiograms. In other series, residual stones are reported in from 10 to 25 per cent of all common ducts explored.⁷ This frequency of overlooked residual common duct stones indicates further the possible value of post-exploration operative cholangiograms, especially with perfected techniques and timely consultations with the radiologist. There is some value of learning by follow-up T-tube cholangiography that a stone remains in the common duct, but detecting the stone before closing the abdomen is far more valuable, since it can then be removed during the same operation. Thomson,⁷ in a series of 39 patients with subsequently proven residual stones, reports that post-exploration operative cholangiograms had been made in 10 instances. In six of these the stones were recognized and removed during the primary operation, while in the other four patients the stones were not seen by the surgeon and consequently were not removed at the opportune time. In each of these four instances the radiologist, in reviewing the films after operation, read them as positive. This again emphasizes the need for radiological consultation during operation (Figures 5 and 6).

Transient Cholangitis

Some instances have been reported in which transient cholangitis has been suspected following operative cholangiography.⁶ However, in no instance was this thought to occur in this series. Only one complication was encountered which might have been related to the cholangiogram. This was a 76-year-old man with acute edematous pancreatitis operated upon for acute cholecystitis in whom an operative cholangiogram was obtained showing common duct stones. Three stones were removed, but one was overlooked. Postoperatively the patient did poorly, dying on the sixth postoperative day with acute hemorrhagic pancreatitis. Good filling of the pancreatic ducts had occurred during the cholangiogram and irritation of the Hypaque® might well have contributed to the hemorrhagic pancreatitis. Five to 10 cc. of dye is ample for outlining the bile ducts and using more than this, particularly if it is injected with too much pressure, might accentuate any potential harmful effects. In this series, with the one possible exception cited above, no untoward reactions from cholangiography were observed.

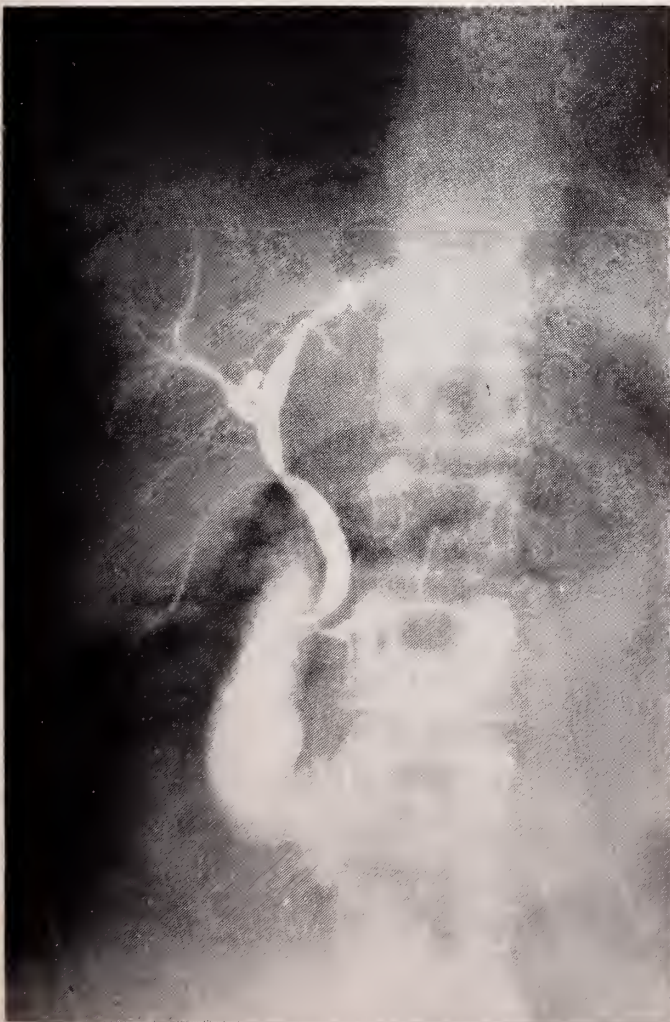


Figure 5: Pre-exploration operative cholangiogram showing rapid egress of the opaque medium into the duodenum and a non-opaque colculus in the common duct. A portion of the pancreatic duct is identified.

The main pancreatic duct was frequently visualized with cholangiography. This is of interest, particularly in those patients with symptoms suggestive of previous mild episodes of pancreatitis.¹

That operative cholangiography is of great value is no less apparent than the fact that palpation, probing, and irrigation constitute a very incomplete method of exploring the common duct.

Summary

One hundred thirty-nine patients, undergoing biliary tract surgery in the Talmadge Hospital prior to February, 1960, were studied by operative cholangiography.

Pre-exploration operative cholangiograms in 88 patients in whom common duct exploration was indicated by signs, symptoms or operative findings gave added reassurance for omitting common duct explorations in 41 instances.

Of the 38 patients without indications for duct exploration, cholangiography led to the exploration of three ducts, with stones being found in one instance.

Ten of the pre-exploration operative cholangiograms gave misleading information. Of these 10 instances, eight were falsely positive, exploration revealing no pathology. The other two were falsely negative, but in one, exploration was carried out because of other indications and a three mm./d stone was removed. The other false negative was an instance of a carcinoma of the proximal common



Figure 6: Pre-exploration cholangiogram showing good visualization of the distal common duct and duodenum, with obstruction in the common hepatic duct. This could be due to carcinoma, but in this instance was proven to be sclerosing cholangitis.

OPERATIVE CHOLANGIOGRAPHY / Engler

hepatic duct which was missed by the surgeon, diagnosed later by the radiologist and proven by autopsy.

In this series of 55 post-exploration operative cholangiograms no stone was disclosed which led to the operative removal of that stone during the initial operation. One stone, missed by the surgeon at the time when he could have removed it, was seen later when the film was reviewed by the radiologist.

Conclusions

Pre-exploration operative cholangiograms are advisable whenever there is doubt as to the validity of the indication for common duct exploration (i.e. small stones in gall bladder).

The value of routine pre-exploration operative cholangiogram in those without indications for duct exploration is debatable.

Although not demonstrated by this series, post-exploration operative cholangiograms are of value and should be performed routinely.

Familiarity with the procedure by both surgeons and radiologists is required to get the maximum benefits from operative cholangiography. This can best be achieved by performing them often and by having radiological consultation during operation.

Medical College of Georgia

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NOTES FROM WASHINGTON

THE SABIN ORAL POLIO vaccine will not be available in sufficient quantity in 1961 for large scale use.

Leroy E. Burney, M.D., Surgeon General of the U. S. Public Health Service, told the recent Clinical Meeting of the A.M.A. that many problems involved in taking the oral vaccine out of the laboratory and into mass production had not been solved.

In light of this fact, both the A.M.A. House of Delegates and Dr. Burney said that large numbers of the U. S. population, including almost half of the children under five, had not been fully vaccinated with the effective Salk vaccine.

Dr. Burney said the problems of integrating the oral vaccine into the present program of immunization against polio "are many and complex."

"Only the future can tell whether control of poliomyelitis will be accomplished through a live, orally administered vaccine, the killed vaccine, or a combination of both," Dr. Burney said.

FDA Issued Stricter Rules

The Food and Drug Administration issued stricter rules, some effective Jan. 8 and others effective March 9, governing promotion and marketing of prescription drugs. The new regulations are designed to insure safe use of the drugs.

Under the new regulations, manufacturers must disclose hazards, as well as advantages, of the drugs in

promotional material sent to physicians. Manufacturers can be denied permission to market drugs they refuse to permit FDA inspection of manufacturing methods, facilities, controls of records.

The FDA deferred until later action on its proposal to require every package of drugs sold to pharmacies to contain an official brochure on their use and hazards. The A.M.A. proposed instead that it be given the responsibility of getting such information directly to physicians.

Foreign Interns

Foreigns interns who failed medical examinations last September may remain in this country until at least next July 1.

In cooperation with the State Department, the A.M.A. agreed to extend for six months a Jan. 1 deadline for dismissal of foreign interns unless they pass the examination through the Educational Council for Foreign Medical Graduates.

The flunking interns will be given another opportunity to take the examinations in April. Meantime, they must be taken off patient care and their hospitals must set up training programs for them.

The A.M.A. Council on Medical Education and Hospitals, said that this policy would be carried out judiciously and that occasional exceptions would be granted where circumstances warranted.

MEDICAL MANAGEMENT OF PATIENTS WITH STROKE

Arriving at an etiologic diagnosis is of primary importance in the skillful management of these patients.

T. Sterling Claiborne, M.D., *Atlanta*

THE TOPIC "Medical Management of Patients with Stroke" may seem relatively simple at first glance, but the physician who handles such patients has a great responsibility in deciding on the etiology of the condition and the most satisfactory treatment to insure both life and as much fullness to that life as possible. To begin with a physician must not assume that he is bound to make over each structure of the body that is diseased in order to carry a person through life. Never underestimate the natural healing capacity of the body tissues.

"Stroke" is used generally to mean a cerebral vascular lesion of some type with paralysis bilateral or unilateral or other focal cerebral disorder. While the major cause of stroke is arteriosclerosis with occlusive thrombus formation, several other bases of stroke need to be considered.

Intracranial Hemorrhage

Intracranial hemorrhage may account for 25 per cent of all strokes, due usually to hypertension and arteriosclerosis, other causes being abnormalities in the blood clotting ability and congenital aneurysms. Hemorrhage may occur in the cerebral tissue itself and if close to the surface leak into the subarachnoid space. In the latter instance the pathology is usually not arteriosclerotic disease, but more often, and particularly in young people, due to rupture of a congenital aneurysm of one of the intracranial arteries or a vascular malformation. Such affairs are usually sudden with symptoms of

acute headache, stiff neck, vomiting, and a little later stroke may or may not develop and also coma or even sudden death occur.

Arterial emboli are less frequently a cause of stroke than the above, but such do occur, particularly in people with mitral stenosis who often have thrombus formation in the atrium. They may also result from a mural thrombus in the left ventricle damaged by a recent myocardial infarct or in endocarditis or congenital heart disease. An interesting feature of cerebral emboli in patients with valvular disease is how satisfactory the course may be. Often there is sudden hemiplegia and just as quickly clearing begins within 24 hours and all signs may be gone within a couple of weeks. To observe the progress of these patients gives the physician some idea of how well the body can adjust to vascular insults.

Brain tumor may cause "stroke" as also meningitis and bacterial endocarditis with brain infection. These more unusual problems need to be considered when a question arises as to diagnosis.

Since arteriosclerosis with occlusive disease is the major cause of stroke, more definitive discussion of this part of the problem is necessary. In the past it has been difficult to obtain accurate statistics in stroke on the location of the thrombosed area of the vessel or vessels involved. One reason for this is because of incomplete pathological studies in patients dying of stroke, often the carotid and vertebral vessels have not been studied thoroughly. Thrombus formation in stroke may take place in the intra-

cerebral vessels or the larger arteries of the basilar, carotid, and vertebral systems. Possibly one-fourth to one-third of the strokes due to thrombotic disease are triggered by a block in the vessels below the circle of Willis, but it must be realized that more than one area of thrombosis may be present in the cerebral vascular system; some old and some fresh. Livingston and Escobar studied the carotid arteries by angiography in 150 stroke patients with trouble in this system. They could divide the patients roughly into three groups of equal number, one-third with block in the internal carotid artery, one-third in the middle cerebral artery, and one-third showed many areas of narrowing and small occlusions. These authors made an interesting observation that the one-third with the proximal block, in general, recovered more quickly and more completely from stroke than the others. Recovery in these patients takes place of course through collateral circulation, three channels being the main ways. The external carotid may feed through the eye vessels to the middle cerebral, the anterior communicating from the other hemisphere to the anterior cerebral and many fine cross channels may become efficient in carrying blood. When collateral circulation can quickly pick up the flow of blood, and in good amount, recovery will likewise be rapid and more complete. Contrarily where such does not occur, fixed stroke will result.

For example, a lady, age 68, had evidence of a very mild cerebral episode five years prior to her present complaint. Recovery was rapid and sufficient to allow her to move about normally, to drive a car, play bridge, shop, and do other things usual to a lady her age. She had a myocardial infarct 13 years prior and angina after that with minor limitations due to pain. Her present episode was left arm weakness and milk confusion; angiogram showed a total block of the left internal carotid evidently dating back to her symptoms of five years ago. The recent problem seemed due to cut down on the good side. In this patient her progress and ocular dynamometry with equal pressures in both eyes indicated that good collateral circulation took over after complete left internal carotid thrombosis. Such was the state at operation.

Episodes of Hypotension

Sometimes in cerebral areas with arteriosclerosis and diminished blood flow, the situation may be made critical by episodes of hypotension resulting from cardiac failure or paroxysmal abnormal rhythms. In such instances, cerebral ischemia may

lead to softening of brain tissue and stroke without the presence of thrombus formation.

Diagnosis Quite Important

The diagnosis is quite important so that one may proceed intelligently in the handling of the patient. A previous history of hypertension, diabetes, myxedema or arteriosclerosis in any part of the body makes arteriosclerotic disease the likely basis of the stroke. If the stroke is due to hemorrhage, it may be manifested by the sudden onset of paralysis with headache and stiff neck, if blood enters the subarachnoid space. Naturally this sequence is not entirely definite and a cerebral thrombosis may give a headache and sudden stroke. Lumbar puncture can quickly aid in determining subarachnoid bleeding and generally is without danger. Often thrombus formation is manifested by preceding signs and symptoms of "arterial insufficiency," just as is the case in certain people with coronary thrombosis who have nibbling angina for sometime in advance of the attack. Mental changes of recent onset with memory difficulties, aphasia, and transient arm or leg weakness or sensory abnormalities may be such indications of diminished cerebral arterial flow. Visual symptoms may be quite variable and indefinite. Should arteriosclerosis cause narrowing in the carotid artery, either common or internal, one may have a bruit over the vessel. This may be either systolic or to and fro. Such a bruit also at times may be heard in the eyeball. Further studies such as eye dynamometry may show a deficiency in flow to the eyeball as a result of carotid artery narrowing. Arteriograms with direct carotid injection can demonstrate blocks and narrowed areas nicely, although as mentioned, a demonstrated block may not be the cause of the present episode. A complete block of the common carotid near its origin will cause absence of pulsation in the vessel, but this is not very frequent.

Of course, the big problem with the stroke patient is what to do. Can the patient profit best with careful medical and nursing management to take them through the acute insult and then rehabilitate them or is it possible by surgical approach to accomplish more? Again, I want to stress what seems to be a misunderstanding even among some physicians. The careful handling medically of vascular problems is not "doing nothing." How does a myocardial infarct or pulmonary infarct heal to restore normal function? Not so much by what you do, but by the growth and enlargement of blood vessels and natural healing mechanisms of lysis and repair. Patients may live and produce with blocked vessels including the internal carotid and with clinical evi-

dence of insufficiency. It is not true that because a patient has carotid insufficiency that they must have a stroke in store for them at any early date. Whether or not anticoagulants will aid the cerebral blood flow, I do not know, but its use is not without danger. I have seen two cases with subarachnoid bleeding and one with intracerebral bleeding when under this therapy.

Carotid Artery Thrombosis

A person with acute onset of stroke due to carotid artery thrombosis of segmental variety may be helped to the extent of avoiding permanent paralysis by thromboendarterectomy. To find such patients and help them requires prompt study of the carotid circulation by angiography and prompt surgical treatment when it is decided upon. Such cases must be selected with care, often more than one vessel is involved, but if a main dam can be relieved with low morbidity and mortality, it should be done. Sometimes, unfortunately, the thrombosis already is extensive when the diagnosis is made.

The patient with a stroke is quite ill for about 24-48 hours and then gradually improves, although, of course, this is variable. The patient needs careful nursing care when unconscious. He must be turned frequently and the skin and subcutaneous tissue kept in good condition. He may be maintained for a few days with intravenous and subcutaneous fluids. This is preferable to nasal feeding at first simply because there is less nasopharyngeal irritation with

subsequent bothersome mucous, but nourishment with food and vitamins is soon essential and tube feeding may be used before the swallowing function returns. A urinary catheter may be necessary, although not often in mild cases. Urinary tract infection is a frequent problem in the cases of catheter usage and should be protected against with antibacterial agents. With the poor pulmonary aeration and regurgitation bronchial infection and pneumonitis are also hazards. Probably all such patients should receive bacterial killers until they stabilize. The patients must be moved frequently, the extremities and the whole body, passively at first, but as soon as possible actively. Within a few days, depending on the severity of paralysis, these people should be gotten out of bed, encouraged, cajoled, and urged toward rehabilitation. It is not easy work and they tend to depression so that optimism in the nurses, family, and physician is of utmost importance. It is wise to have a pattern of rehabilitation exercises with a schedule of increasing effort and accomplishment. Arthritis and painful joints and tendons develop rapidly in paralyzed extremities and must be actively avoided. Specific details of methods of rehabilitation have been arranged in booklet form and are available for both physician, physiotherapist, and patient through the heart association. The return of people with stroke to active life is a challenge and a hard one, but it can be done in many cases.

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A.M.A. TO ASSUME NEW LEADERSHIP

"... Resolved, that the House of Delegates directs the Board of Trustees and the Council on Medical Services to assume immediate leadership in consolidating the efforts of the American Medical Association with the National Association of Blue Shield Plans, the American Hospital Association and the Blue Cross Association into maximum development of the voluntary non-profit prepayment concept to provide medical care for the American people . . ."

By this resolution, adopted in Washington, November 30, 1960, the A.M.A. served notice of its firm commitment to the voluntary non-profit plans as the primary instrument through which America's free medical profession and its voluntary hospital system hope to meet the challenge of the future in providing medical services.

This resolution also placed the A.M.A. in its rightful place of leadership in supporting and guiding the de-

velopment of Blue Shield. It goes far to assure that organized medicine at the national level will henceforth demonstrate the same direction and support for Blue Shield that the leaders of so many states and county components of A.M.A. have given local Blue Shield Plans from their very inception.

A great opportunity confronts A.M.A. in this new role. By exercising bold and imaginative leadership, A.M.A. may be able to help raise the general level of Blue Shield performance to the point where the "voluntary non-profit prepayment concept" will have proved its case to the American people. Certainly there's much to be done to establish standards for Blue Shield and to bring the performance of all Plans up to the level of the best.

It's none too soon for this leadership to make itself felt!

LOCAL BURN CARE

Good surgical judgment is essential in the local treatment of burns, if a satisfactory result is to be obtained.

J. D. Martin, Jr., M.D., *Atlanta*

LOCAL CARE IS OF paramount importance in treatment of the severely burned patient, however, it does not have first priority. After the initial problem of fluid, electrolyte, and colloid replacement has been met, it is necessary to undertake local care of the wound with utmost diligence to promote adequate rapid healing, to prevent infection and nutritional disturbances, and to lessen the complications from an unhealed burn.

Both the open and closed methods of treatment are widely used and under varying circumstances each is considered as the effective method.

Strict Aseptic Conditions

Treatment of a burn should be carried out under strict aseptic conditions, when possible. At the onset, the wound should be cleansed, regardless of whether it is to be treated by exposure or with dressings. The use of a bland detergent or mild soap and copious quantities of physiological saline solution is advised. The wound may be superficially debrided, surgically removing loose tags of debris and necrotic tissue. Extensive debridement is not indicated, moreover this may be harmful. The opinion at present seems to favor puncture of blisters as part of this superficial debridement.

If the open technique is used, the patient is placed on sterile or freshly laundered sheets. Within a period of 48 to 72 hours, a dry eschar will form, which will serve as a protective covering. This may assist in preventing invasion of infection and certainly seal the surface of the wound. The pain induced by the

air, which comes in contact with the exposed wound, will thereby be lessened. The eschar should be carefully observed and when cracks occur they should receive immediate attention. These can be excised under aseptic conditions and the open burn is covered with a fine mesh gauze and an abundant dressing.

In superficial or partial thickness burns, healing will take place in approximately two weeks with exposure treatment. Deep full-thickness burns (third degree burns) do not heal when the eschar softens. Therefore, indication is for debridement, if possible, and immediate grafting.

The exposure method, which is only to be used in the pregrafting phase, allows considerable ease in handling. To accomplish what is ultimately desired, early removal of dead tissue is in order, either by separation or surgical excision.

Certain advantages and disadvantages exist with the open treatment, although the former are more numerous. According to Brown,¹ exposure facilitates the removal of a "warm, moist environment conducive to infection," allows continuous inspection and does not require as much equipment and the exposure treatment is thought by some to be less likely to become infected. This latter advantage has been questioned as will be discussed later.

Burns of Face and Perineum

Burns of the face and perineum are most satisfactorily treated by exposure. Other areas, however, are more difficult to manage in this manner. Circumferential wounds of the trunk make complete exposure less successful. Burns of the hands are often

From the Joseph B. Whitehead Department of Surgery, Emory University School of Medicine, Atlanta, Georgia.

badly macerated when thus treated, therefore, should be dressed and fixed in a position of maximum function. The open method is not the one of choice in burns of the neck, since a firm coagulum is slow to form due to motion and contact which usually occurs. Early disturbance of the eschar permits bacterial invasion with marked infection. Patients treated without dressing are difficult to transport. Van Petten² presents a more subtle disadvantage to the open method when he states that the open method appears to patient and relative as if no treatment is being attempted.

Closed Treatment

The closed treatment has long been acceptable and may be used in many forms. The wound should be cleaned, as described above, and followed by superficial debridement. The immediate covering should be a single thickness of fine mesh gauze, or it may be impregnated with petrolatum. According to Artz,³ a water soluble ointment should be used for ease in removal. The second layer should be several thicknesses of a fluffy gauze, mechanics waste,⁴ or a cellulose-cotton.^{5,6} This must be thick and quite absorbent and secured by firm elastic type bandage to prevent further escape of serum from the surface. Care must be taken when this form of dressing is used to exert pressure evenly over the entire area of the wound and not constrict or produce ischemia.

The place and time of subsequent dressing changes is an important factor in the response and results of the closed treatment. Opinion concerning the time of initial change varies from four days to two weeks, depending on discomfort, elevation of temperature, or drainage. Thereafter, the dressing is changed periodically to remove the debris, to prevent further bacterial invasion, and to provide conservative debridement. Frequency of the dressing change depends on the condition of the patient, severity of the burn, and other factors.

Best Protection Against Infection

Advocates of the closed method maintain that it offers the best protection against infection. Lowberry and co-workers⁷ obtained data which showed that more pathogens could be found on burns treated by exposure than on burns treated by closed method. Other advantages of the closed method include increased ease in treatment of circumferential burns, relief of pain through splinting, added warmth, facilitation of maintenance of joint function, and satisfactory transportation of patients. A disadvantage

lies in trauma associated with initial and subsequent dressing changes and the need for some type of anesthesia at this time.

Neither method is greatly superior and certainly each has its merits which permit effective use under varying circumstances. Exposure treatment may become necessary and even invaluable in treatment of mass burn casualties resulting from any cause.

Antibiotics are commonly used to combat infection, both in the early and later stages of burn treatment. Their benefit varies with the severity of each burn and response will depend on the use of the specific type for the involved infection. Although the effectiveness of local antibiotics is not yet conclusive, erythromycin-polymyxin ointment is used when infection occurs from gram negative organisms.⁸ Neomycin in various combinations has been effective to some extent. Gelb⁹ suggests that antibiotics not only controlled infection, but implied that early grafting might have been permitted. However, it is maintained by some that asepsis and general cleanliness are as effective in controlling infection as are antibiotics applied locally.^{10,11} Since there are no proven advantages for routine use, ACTH and cortisone are not indicated.¹²

The eschar of full thickness burns must be removed early to permit satisfactory grafting. This can be achieved by either conservative debridement at dressing changes, by enzymatic or chemical debridement or by surgical removal.

Enzymatic Debridement

Enzymatic debridement presents many problems and for large burns is not practical. According to Artz,¹⁰ the chemical agents for the removal of eschar seem to be no better than wet saline soaks. The associated maceration may constitute a definite disadvantage.

Many efforts have been made at attempting chemical debridement of the third degree burn. The purpose is to remove the destroyed tissue without too much delay, discomfort, morbidity or mortality. There have been many problems entailed in such efforts. These primarily consist of the ineffectiveness of the materials which have been used, the time involved, and with the use of some of the recent, newer methods, expense may be no small item. One of the first materials used was pyruvic acid, devised some 20 years ago. This is still being used as the active ingredient in combination of antibiotics, which consists of the following proportions:¹³

bacitracin	50,000 units
neomycin	0.5 gm.
polymyxin B. sulfate	0.1 gm.

LOCAL BURN CARE / Martin

pyruvic acid	20.0 gms.
methyl p-hydroxybenzoate	1.33 gms.
propyl p-hydroxybenzoate	0.33 gm.
water soluble base	1,000 gms.

Enzymes Used for Debridement

Enzymes used for debridement may be considered for their proteolytic and fibronolytic activity. Tryptar®¹⁴ is an example of the proteolytic group. The more commonly used enzymes are trypsin, chymotrypsin,¹⁵ and nine amino-acudine. The peptidases from *Clostridium histolyticus*¹⁶ are further examples of protein digestants, as is also proteinase-a. More recently debricin (ficus protease)¹⁷ in various combinations has indicated considerable promise and may be capable of achieving much success for this method of debridement. Ficin has been used in varying combinations from 15 to 20 per cent solution in a two per cent acetic acid paste. It is admitted that acceptance of these agents has not been universal. Until a more satisfactory method is obtained, the surgical debridement offers the quickest and most satisfactory method of removing the destroyed tissue from the third degree burn.

Immediate surgical removal may be too drastic in the large burns and should be employed only when the condition of the patient permits. Perhaps this may best be limited to burns of under 25 per cent surface areas.

Grafting After Surgical Debridement

Grafting should take place as soon as possible after surgical debridement. Lack of donor areas for grafts can be a problem in extensive burns. Certainly when over 50 per cent of the body surface is involved, sufficient skin cannot always be obtained from the patient. The initial use of homografts from donors or from cadavers can assist in conserving this shortage. These have greatly aided in the benefit derived from early coverage of these extensive body burns and preventing the familiar negative nitrogen balance. Electrolyte disturbances and profound anemia slows the normal processes of healing if the involved areas are not covered.

Summary

Although much recent information has been gained, the local care still affords one of the major problems in hastening the early recovery from the devastating effect of burns. The immediate care still constitutes the essential approach in correction of

the deficits responsible for the abnormal physiological processes. The magnitude of the burn is directly related to the immediate response to systemic treatment, the size of the involved area, and the availability of tissue to replace the extensive destruction. The local and systemic infection can be lessened if early healing can be hastened. Until one is able to resurface the local area, this will continue to offer difficulty both in the control and prevention of a large number of complications. The mortality from burns has been materially reduced, except in those which are considered of less magnitude and are not vigorously treated. This can occur by a delay, from various causes, which allows the subsequent complications to develop. It is felt that if both morbidity and mortality are to be effectively reduced, prevention of burns plus a more vigorous approach to the systemic and the local care is essential.

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1961 CALENDAR OF MEETINGS

State

- Feb. 28-Mar. 2—"Management of Your Patient with Vascular Disease," Medical College of Georgia, Augusta.
- Mar. 2-4—Georgia Society of Ophthalmology and Otolaryngology, General Oglethorpe Hotel, Wilmington Island, Savannah.
- Mar. 10-11—"The Physical Examination of the Cardiovascular System," Grady Memorial Hospital Auditorium, Atlanta.
- Mar. 20-24—Basic Science Lecture sponsored by the Sisters of Mercy and the Medical Staff of St. Joseph's Infirmary, St. Joseph's Infirmary, Atlanta.
- Mar. 21-23—"Gynecology in General Practice," Medical College of Georgia, Augusta.
- May 7-10—Annual Session, Medical Association of Georgia, Atlanta Biltmore Hotel, Atlanta.**
- June 11-14—Georgia Pharmaceutical Association, Biltmore Hotel, Atlanta.

Regional

- Mar. 6-9—Southeastern Surgical Congress, Deauville Hotel, Miami Beach, Florida.
- Mar. 6-9—New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, Louisiana.
- Mar. 10-11—Southeastern Chapter of the Society of Nuclear Medicine, The Academy of Medicine, Atlanta, Georgia.
- Mar. 20-22—Dallas Southern Clinical Society, Statler-Hilton, Dallas, Texas.
- Apr. 9-12—Tennessee State Medical Association, Read House Hotel, Chattanooga, Tennessee.
- Apr. 22-25—Texas Medical Association, Galvez and Buccaneer Hotels, Galveston, Texas.
- Sept. 25-26—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tennessee.
- Nov. 6-9—Southern Medical Association, Municipal Auditorium, Dallas, Texas.

National

- Mar. 6-10—Postgraduate Course in Recent Advances in Cardiovascular Disease, The Mount Sinai Hospital, New York, New York.
- Mar. 9-11—Eastern Conference of Radiology, Lord Baltimore Hotel, Baltimore, Maryland.
- Mar. 12-17—American College of Allergists Graduate Instructional Course and Seventeenth Annual Congress, Statler-Hilton, Dallas, Texas.
- Mar. 13-17—Postgraduate Course in Internal Medicine: Selected Topics, McGill University Department of Medicine, Montreal, Canada.
- Mar. 13-25—Postgraduate Course in Laryngology and Bronchoesophagology, Department of Otolaryngology, University of Illinois College of Medicine, Chicago, Illinois.

- Mar. 20-24—Postgraduate Course in Medical Technology, University of Colorado Medical Center, Denver, Colorado.
- Mar. 20-24—American Surgical Association, Boca Raton Hotel, Boca Raton, Florida.
- Mar. 20-24—Postgraduate Course in Advanced Clinical Electrocardiography, University of Tennessee College of Medicine, Memphis, Tennessee.
- Mar. 23-25—Postgraduate Course in Endocrinology and Metabolism, University of Virginia Medical Center, Charlottesville, Virginia.
- Apr. 3-8—The Gill Memorial Eye, Ear and Throat Hospital, 34th Annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties, Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Virginia.
- Apr. 3-15—Eleventh Medical Conference, Bahamas Conferences, Nassau, Bahamas.
- Apr. 6-8—Fourteenth Annual Meeting, West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Virginia.
- Apr. 10-12—American Academy of Pediatrics, Sheraton-Park Hotel, Washington, D. C.
- Apr. 12-15—Postgraduate Course in Problems of Growth and Aging, The Lankenau Hospital, Overbrook, Philadelphia, Pennsylvania.
- Apr. 17-20—American Academy of General Practice, Miami Beach, Florida.
- Apr. 21-28—American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach, Florida.
- Apr. 30-May 6—Conference on Internal Medicine, Bahamas Conferences, Nassau, Bahamas.
- May 2-3—American Pediatric Society, Hotel Traymore, Atlantic City, New Jersey.
- May 5-7—American Society of Internal Medicine, Eden Roc Hotel, Miami Beach, Florida.
- May 8-12—American College of Physicians, Americana Hotel, Miami Beach, Florida.
- May 8-12—American Psychiatric Association, Morrison Hotel, Chicago, Illinois.
- May 15-19—Postgraduate Course in Gastroenterology, University of Pennsylvania Graduate School of Medicine, Philadelphia, Pennsylvania.
- May 16-20—American College of Cardiology, Inc., Biltmore Hotel, New York, New York.
- June 19-23—Postgraduate Course in Current Aspects of Internal Medicine, State University of Iowa College of Medicine, Iowa City, Iowa.
- June 22-26—American College of Chest Physicians, Hotel Commodore, New York, New York.
- June 26-30—American Medical Association, Annual Meeting, New York, New York.**
- Oct. 15-20—Fourth International Congress of Allergology, the Hotel Commodore, New York, New York.



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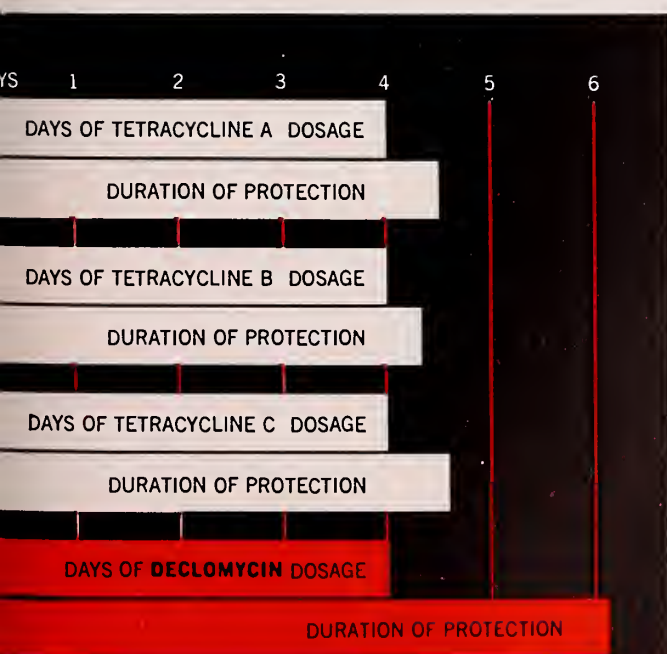
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PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

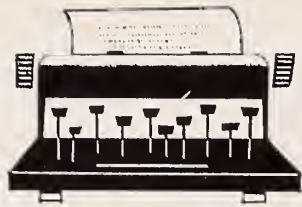
SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

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editorials

The ?? Cost of Medical Care

IT IS THE PHYSICIAN'S *responsibility* and the patient's *right* to know about the costs of health care.

Rather than presenting dull statistical material on this subject, the American Medical Association has designed and published an attractive 16-page cartoon pamphlet explaining medical care costs in the light of today's over-all rising prices.

The pamphlet graphically displays what portion of the consumer dollar is spent on health care. It compares today's health care costs with the fees and charges of pre-inflation days, and other commodities and services.

Another page of the pamphlet portrays how the health care dollar is spent and what it buys. It also shows the spectacular progress of medical science in making new services available at comparatively little additional costs—which enable the patient to

spend less per illness than in days gone by.

Enclosed with this issue of the *Journal of the Medical Association of Georgia* is the new AMA pamphlet, published as a supplement to the *Journal*. Read it—know it—and explain it to your patients and friends. The MAG has a supply of 2,500 of these pamphlets for distribution to its membership. Any physician may order these pamphlets from MAG up to maximum lots of 25 pamphlets at no charge. As additional pamphlets are only available at a cost of five cents per copy, complementary orders will be received and filled on a “first come—first served” basis.

Satisfying the public about the costs of medical care is part of the practice of medicine. Use this data as a specific in allaying the patient's concern about the costs of health care.

The Family Doctor Problem

AMERICAN MEDICINE IS PROUD of its great heritage and its inherent capability in providing the best medical care in the world for the people of this country. This is rightly so, because the free enterprise system of medicine has worked so well in our country that we must preserve it. We believe the majority of people want it preserved.

In our great fight to retain our medical system

from the great disease of socialism, we may be overlooking the “supposedly” lesser evils that are actually weakening us to a degree that we cannot continue the fight.

In our changing times when everything considered a product of the modern age is supposed to be good and everything held over from other years is outdated, the family doctor may be included in this

mode of thought and ushered from the medical scene to give way to super specialization. This could be one of the evils that might weaken our foundation.

There are those who would lull American medicine into the false belief that complete specialization is the modern approach and, therefore, the best approach for organized medicine. In my opinion, total specialization is just as much a pitfall for our medical system as no specialization would be. The American people have repeatedly demonstrated that they want a family physician. In the larger cities, they may turn to the surgeon, the pediatrician, or the obstetrician who has previously performed a service for their family. With this in mind, is there a solution to the family doctor problem in this modern age? Are we to turn out "first aid M.D.'s" who will give pre-op and post-op care; prenatal and post-natal care; treat minor illnesses and small injuries, and act as a clearing house for the specialties? If so, who is getting first consideration, the people or the doctors?

In the November 1960 issue of the *Journal of the Medical Association of Georgia*, Dr. John Phinizy presented a good approach to such problems. His evaluation of certain specialists attitudes was well-worded. He pointed out many of the problems facing the aspiring GP today when he singled out our poor general practice residency program, the fancied fear of the partly-trained GP, and the hospital situation as it now exists. Students interested in becoming GP's find it much easier to specialize. The suggestions Dr. Phinizy made warrant close scrutiny by our leaders as they plan for the future.

In my opinion, a three-year residency program would be too long at the outset and I would propose that our medical schools pioneer a new general practice training program of two years duration. This should be done in affiliation with community hospitals where material exists and where people with

the "total training or none theory" could not destroy the program by giving all the cases to the specialty trainees. It should not end there, but should be tied in with the postgraduate training courses offered at the Medical College of Georgia and elsewhere.

Hospitals should be encouraged to provide better study facilities for staff members centered around an interested pathologist. City hospital trainees should be encouraged to "cut the cord" and move out into the smaller communities where they might be surprised at the welcome they would get.

Hospitals must give recognition to the general practitioner without selfish regulations designed primarily to cut competition. Learned men can be petty as they judge their competitors jealously rather than realizing that a strong medical community helps the practice of all.

I contend, therefore, that American medicine does have an answer. Just as better training has improved medicine in the specialties, so must better training improve medicine in the general practice. The established GP's of this state know that the solution to the problem is good training and are ready to work toward that end through the Georgia Academy of General Practice, but help is needed. Every man in organized medicine should consider the problem, decide what he thinks is best, then speak out and let it be known.

The evils are weakening the foundations of American medicine and our enemies are standing by to watch us fall. Once we weaken our system to the point that we cannot command the respect of the American people, we are doomed to defeat, and there will be *no* second chance.

Joseph B. Mercer, M.D.
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Brunswick, Georgia

Disorders of Sex Maturation

RECENT ADVANCES IN THE field of sex differentiation include the following:

(1) The delineation of an abnormality of adrenal steroid synthesis which can explain the clinical features of adrenal virilism.

(2) The discovery of a cytologic test for chromosomal sex.

(3) The association of chromosomal abnormalities with two well-recognized abnormalities of human sex development.

As a result, there has been the stimulation of interest in this field as well as a confusion of terminology. A recently published review of the subject by Dr. Lawson Wilkins* provides a clear and concise summary of present knowledge on this subject.

Briefly considered, the abnormalities of sexual development may be classed into three broad categories, which include gonadal dysgenesis, male pseudohermaphroditism, and female pseudohermaphroditism.

Gonadal Dysgenesis

This category includes those disorders of sex development associated with a gonadal anomaly as follows:

(1) *Turner's syndrome*: This picture is comprised of a group of congenital anomalies including short stature, web neck, failure of puberty, syndactyly, and gonadal aplasia with female accessory sex structures. This condition may be recognized at birth by the presence of characteristic lymphedema and redundant folds at the nape of the neck. There is a high incidence of congenital cardiovascular defects. The nuclear chromatin may be positive (female) or negative (male). The chromosomal pattern may then be XO or XX. The chromosomal count has been observed to be 45 instead of the normal 46 in the chromatin negative individuals.

(2) *Rudimentary Testes*: This syndrome is closely related to Turner's syndrome. The gonadal picture is less severe, there being microscopic rudiments of testes or testis and ovary. The presence of these rudiments produces a varying picture of male, female or mixed accessory sex structures and external genitalia. The nuclear chromatin is negative, and the chromosomal pattern may be XY or XO.

(3) *Klinefelter's Syndrome*: This condition is recognized by the association of gynecomastia, azoospermia, and testicular atrophy. Seminiferous tubule hyalinization is the characteristic testicular pathology. Accessory sex structures are male as are the external genitalia. Android puberty usually occurs, though this may be deficient. These individuals may be chromatin negative or positive. The chromosomal pattern may be XXY or XY.

(4) *True Hermaphroditism*: By definition there is the presence of both ovary and testicle in the same individual. Accessory sex structures may be male or female or mixed. External genitalia are usually ambiguous or male. Puberty may be gynecoid or

android. Nuclear chromatin may be positive or negative and chromosomal pattern may be XX or XY.

Male Pseudohermaphroditism

Here, the fetal testis, though morphologically developed, appears to have failed to induce appropriate development of accessory sexual structures and external genitalia.

(1) *Ambiguous or Male Type*: This condition is characterized by the presence of testes (intra-abdominally or externally) with ambiguous or male external genitalia. The accessory sexual organs may be male or female. Puberty may be android or gynecoid. The nuclear chromatin is negative, and the chromosomal pattern is XY.

(2) *Syndrome of Testicular Feminization*: This striking picture is characterized by the presence of female external genitalia. Testes are located intra-abdominally, labially, or in the groins. The accessory sexual organs are incomplete or absent, the vagina ending as a blind pouch. Puberty is fully gynecoid. Nuclear chromatin is negative and chromosomal pattern is XY.

Female Pseudohermaphroditism

Androgenic steroids from a fetal or maternal source may cause varying degrees of virilism in chromosomal females. In all examples the ovaries are normal. Accessory sexual organs are female. External genitalia are variable (from penis with empty scrotal sac to slight enlargement of the clitoris). The nuclear chromatin is positive and chromosomal pattern is XX.

(1) *Congenital Virilizing Adrenal Hyperplasia*: Puberty is precocious and virilizing unless treatment with glucocorticoids is carried out.

(2) *Extra-uterine Androgenic Steroids*: Maternal androgen-producing tumors, administration of testosterone and synthetic progestational synthetic steroids have been incriminated in virilized female infants.

(3) *Unknown Cause*: Puberty is gynecoid.

One of the most important contributions to the clinical management of abnormalities of sexual development comes out of the psychological study of a relatively large group of these individuals by Money and his associates.*

Gender role, an individual's personal view of his sex, is notably independent of his chromosomal pattern, nuclear chromatin, gonadal structure or hormones. On the other hand, gender role depends on the parental assignment of sex and, indirectly, on external genitalia, since this is the indication parents use in assigning their child's sex. Though gender

*Wilkins, Lawson: *Abnormalities of Sex Differentiation: Classification, diagnosis, selection of gender of rearing and treatment*, Pediatrics 26:846, November, 1960.

*Money, John; Hampson, Joan, and Hampson, John L.: *Hermaphroditism: Recommendations concerning assignment of sex, change of sex and psychological management*, Bull. Johns Hopkins 97:284, 1955.

role is psychologically determined, it is nevertheless irrevocable once established. A change of sex after the age of 18 months may have disastrous psychological repercussions. Under special circumstances, however, a change of sex might be accomplished with good results in an older individual, especially if he had harbored a secret conviction of other-sexness.

It follows, then, that in cases of ambiguous sex the physician plays a most important role in arriving at an early, unequivocal recommendation to the parents. This is based on a diagnosis of the anomaly, the morphology of the case in question and the natural history of the anomaly in terms of what to expect at the time of puberty.

The importance of sex chromatin examination lies in its use in the differential diagnosis of ambiguous sex, not in assigning sex. For example, a new-

born infant with ambiguous external genitalia, positive sex chromatin, normal 17-ketosteroid excretion, and a history of maternal synthetic progesterone administration early in pregnancy would have iatrogenic female pseudohermaphroditism as the most likely diagnosis. The preferred assigned sex would be female, no hormone treatment would be necessary and clitoridectomy, if necessary, would be accomplished early in life.

The neonatal pediatric examination provides an excellent opportunity to pick-up abnormalities of sex differentiation. The examiner should be alerted to further investigate an infant if there is hypospadias, cryptorchidism, female genitalia with masses in the groins or labia, or siblings with sex anomalies.

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LOCKHEED EMPLOYEES DONATE RESPIRATORS

LOCKHEED EMPLOYEES, through their "Buck-of-the-Month" Club, have donated respirators to 19 hospitals in 17 North Georgia counties in which these aircraft workers reside.

As a surprise Christmas gift, the employees made the presentation to hospital administrators in a ceremony at the Lockheed plant in Marietta. They had been summoned to the session "to discuss hospital affairs" by Glenn Hogan, of Atlanta, executive secretary of the Georgia Hospital Association. Dr. John Mauldin of Atlanta, secretary of the Medical Association of Georgia, who outlined the desirability of hospitals being equipped with a respirator for use in oxygen therapy; Dr. J. E. Griffith of Lockheed's Medical Center, and Bill Rieke, assistant general manager of Lockheed's Georgia Division were present for the ceremonies.

John McGahee, Norman King, W. A. (Bill) Turner, and Paul Young of the "Buck-of-the-Month" Club made the presentations to the various hospitals.

A portable resuscitator was given to the Dawson County Health Clinic, home of the Georgia Nuclear Laboratories operated by Lockheed for the Air Force. J. C. Burt of Dawson County, employee of the laboratories, made this presentation.

Hospitals receiving the respirators follow:

Bartow County . . . Howell-Quillian Hospital in Cartersville, represented by Dr. W. B. Quillian and Frank McConnell.

Carroll County . . . Tanner Memorial Hospital in Carrollton, represented by J. W. Warren, and Villa Rica

City Hospital represented by Mrs. Ruth Robertson.

Cherokee County . . . Jones Memorial Hospital (under construction).

Cobb County . . . Kennestone Hospital in Marietta, represented by Millard L. Wear.

DeKalb County . . . DeKalb General Hospital in Decatur, represented by William H. Thrasher.

Douglas County . . . Douglas County Memorial Hospital in Douglasville.

Floyd County . . . Floyd Hospital in Rome, represented by George Hatcher.

Forsyth County . . . Forsyth County Hospital in Cumming, represented by Henry A. Thornton.

Gilmer County . . . Watkins Memorial Hospital in Ellijay, represented by D. A. Higgins.

Gordon County . . . Gordon County Hospital in Calhoun, represented by J. L. Spink.

Gwinnett County . . . Button Gwinnett Hospital in Lawrenceville represented by Jack G. Whelchel.

Hall County . . . Hall County Hospital in Gainesville, represented by Fred M. Walker, Jr.

Haralson County . . . Bremen General Hospital in Bremen, represented by H. Chalmers Jones.

Paulding County . . . Paulding County Hospital in Dallas, represented by Mrs. Lucille Womack.

Pickens County . . . Roper Hospital in Jasper, represented by Mrs. Helen E. Roper.

Polk County . . . Polk General Hospital in Cedartown, represented by Thomas B. Wolfe, Jr., and Rockmart-Aragon Hospital in Rockmart, represented by Thomas R. Pettet.



heart page

AURICULAR ARRHYTHMIAS AND ACUTE MYOCARDIAL INFARCTIONS

Edward R. Dorney, M.D., *Atlanta*

ATRIAL FIBRILLATION AND atrial flutter occur as a complication of myocardial infarction in six per cent and one per cent of cases, respectively. With the exception of occasional transient bouts of atrial fibrillation during the first few days after acute infarction, appearance of these arrhythmias is usually a serious prognostic sign. They tend to occur in more seriously damaged hearts, particularly in those previously enlarged by coronary or hypertensive disease.

The factors involved in the production of the atrial arrhythmias, particularly atrial fibrillation, seem to be multiple. James⁴ has recently shown in 10 of 11 cases of myocardial infarction complicated by atrial fibrillation that at post-mortem areas of hemorrhage could be demonstrated in the immediate vicinity of the SA node. He was also able to demonstrate that in each of these cases the main coronary vessels had been occluded proximal to the branch which supplied the area of the SA node. Gross⁵ has shown that the right coronary artery supplies the SA node in 60 per cent of the cases, the AV node and bundle of His in 90 per cent, and the inferior surface of the heart in 90 per cent. This correlates well with the clinical observation of others that atrial and nodal arrhythmias are more common with inferior infarctions. It has also been demonstrated that atrial fibrillation is difficult to produce and maintain in the normal atrium but that the enlarged, irreg-

ularly, damaged, anoxic chamber is a fertile ground, presumably because of the occurrence of multiple contiguous strips of muscle with variable refractory periods.

Atrial fibrillation most commonly occurs early in the course of myocardial infarction. Many episodes will occur in the first few hours after infarction and about 90 per cent within the first week. Frequently, this arrhythmia is transient and will revert spontaneously within minutes and not recur. In such cases full digitalization is indicated for the purpose of controlling the ventricular rate should the arrhythmia reappear. Quinidine should not be used as a prophylactic medication to prevent recurrence, since it has been shown that this drug may be a source of arrhythmias in the anoxic heart. Persistent fibrillation can be a medical emergency and should be treated vigorously. The immediate problem is the control of the ventricular rate. This is best accomplished by the slow intravenous injection of 0.5 to one mg. of Lanoxin® with additional increments given at two hourly intervals until the rate is controlled or the fibrillation reverts to normal sinus rhythm. When the rate is controlled or the rhythm corrected the patient should then be maintained on digitalis. If failure persists despite adequate digitalization and control of heart rate, conversion of the rhythm with Quinidine Sulphate® should be at-

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

tempted in order to obtain the additional increment of cardiac output (up to 30 per cent), supplied by return to normal sinus rhythm. Quinidine Sulphate® may be given in oral doses of 0.2 of a gram q2h for five doses. If this is unsuccessful, the dose may be raised to 0.4 of a gram on a similar schedule beginning 12 to 14 hours later. Oral quinidine gluconate should not be used in this particular dosage schedule since peak levels are much more prolonged than with Quindine Sulphate® and toxic levels may be easily reached and maintained. The patient treated with quinidine following myocardial infarction should be monitored with an EKG. Molar sodium lactate for intravenous injection and a cardiac pacemaker should be immediately available during the attempts at reversion of the rhythm.

Atrial flutter presents a more serious prognosis than does atrial fibrillation. It is almost always associated with severe cardiac damage and congestive failure. In Askey's series² there was an increased mortality even in those cases in which the rhythm was reverted to normal. Treatment was the same as described for atrial fibrillation, control of the ventricular response by increasing the A-V block being the primary consideration. After extremely large doses of digitalis are required to accomplish this.

Paroxysmal atrial and nodal tachycardias are rare occurrences with myocardial infarction; are usually self-limited, but may be dangerous if the rapid ventricular rate is prolonged. Treatment consists of maneuvers such as carotid sinus massage, digitalis, or pressor agents such as Neo-Synephrine® and Levophed®.

A-V dissociation and sinus bradycardia are potentially dangerous rhythms in myocardial infarc-

tions since both predispose to the emergence of lower pacemakers with ventricular tachycardia or fibrillation.

In sinus bradycardia the duration in the fully repolarized state of the ventricle is prolonged, so that any ventricular focus firing during this period could usurp the function of the pacemaker of the heart. Atropine, by decreasing the vagal influence on the sinus pacemaker, increases the frequency of conduction through the normal pathways and lessens the possibility of ectopic control of the heart. This drug should be given in an initial dosage of one mg. intravenously and repeated as necessary to maintain a rate of 100, plus or minus 10. Smaller doses by other routes are many times ineffective. After initial speeding of the rate has been accomplished oral preparation such as Pro-Banthine® may be tried for maintenance. The parenteral route should be used again if this is ineffective.

In A-V dissociation a lower pacemaker, usually in the A-V node, has already taken over by virtue of the fact that it's inherent automaticity is greater than that of the SA node. The danger is in the possibility that the pacemaker may slip lower in the conduction system with the emergence of ventricular arrhythmia. Atropine in this case enhances conduction through the A-V node, increases the rate of the sinus pacemaker, and by this means suppresses the lower pacemakers.

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LIABILITY OF HOSPITAL FOR INJURY SUSTAINED BY MENTALLY DISTURBED PATIENT QUESTION FOR JURY

PLAINTIFF'S WIFE WAS mentally disturbed. About an hour and 15 minutes after she had been admitted to the defendant hospital, she jumped out of the bathroom window. She fell three stories and sustained severe injuries. The lower court directed a verdict for the hospital. On appeal, the Court of Appeals of Georgia held that the question of the hospital's negligence should have been submitted to the jury and, accordingly, reversed the lower court's decision. The basic issue in the case was: Did the hospital have notice of the patient's condition? The Court of Appeals of Georgia held:

"The hospital did have notice of the patient's mentally disturbed condition, and it cannot be said

as a matter of law that they were freed from responsibility because this notice was not in writing contained in the specific instructions brought to them by the patient's husband at the physician's request. There was enough evidence as to the patient's appearance on arrival to make a jury issue as to whether trained staff members should not then have recognized her irresponsible condition. They did not, rightly or wrongly, keep constant watch over her, and they did allow her to wander away by herself."

Misfeldt v. Hospital Authority of City of Marietta, 115 S.E. 2d 244 (Georgia, April 14, 1960).



mental health page

THE PSYCHIATRIC EXAMINATION

Z. Sweeney Sikes, M.D., *Macon*

THE CLASSICAL PSYCHIATRIC examination should include the time-honored topics of attitude and general behavior, affect and mood, content, orientation, memory, general information and school knowledge, knowledge of current events, and judgment. Too many examiners, however, exclude and even prevent spontaneity on the part of the patient. The patient may desperately try to tell the physician what is bothering him, while the physician time and again interrupts him to get on with specific headings of the examination. Nor should the theme of this idea be excluded from other fields of medicine.

Man is endowed with a facility for health in the emotional as well as in the physical sphere. This facility is called by various terminologies including homeostasis, intuition, balance or horse sense. I feel that it is this facility which we allow to emerge in order to bring about successful psychotherapy. It is the duty of the physician to set the stage or atmosphere whereby man's natural capacity may assist the physician and the patient to accomplish what we set out to do: get the patient well, if possible. Why, then, should this same capacity not be utilized in the development of a good history?

A simple device to use is routinely to give the patient a chance to tell where he hurts, either emotionally or physically. Such a procedure is to ask the patient simply, "Could you tell me what is troubling you?"

Many surprising responses are the reward of this

question because it leaves the field wide open for the patient. It is useful to the psychiatrist even in the patient who responds with, "I don't know, Doc, that's why I came to you." More often, when the patient senses that you are giving him the chance to tell about his problems, he immediately begins to relate a clear and concise story. Many times a patient referred by an internist because of somatic complaints with negative physical findings will begin, "I don't know where I should start, but for a long time I've been having trouble getting myself organized. I get upset by the least thing people say and find myself taking everything personally."

I recall very well a man I saw on a medical ward in a general hospital where extensive laboratory tests and x-rays had been done. The attending physician, really in anger, requested a psychiatric consultation. He had reviewed every system in the book and he said he had found nothing to support any disease, although the patient had many physical complaints when a thorough system review was carried out. To the direction, "Tell me what is troubling you," the patient immediately responded, "Doctor, I'm afraid I'm going to kill myself and I can't sleep. I've been trying for a week to tell that other doctor, but he asks me so many questions I haven't had a chance to tell him."

All the while the psychiatrist may make note of what the patient is saying, at the same time gathering information for the usual topics which are to be

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

covered. All those not covered by the patient's own productions can be completed by later questioning. For instance, when a past history is obtained, information regarding dates, ages, and even the patient's judgment are being given. For content, the psychiatrist may develop his own leading questioning in order to bring out delusional ideas which may not be given spontaneously.

The psychiatrist should not overlook the possibility of somatic disease. Many undiagnosed diseases are seen by a psychiatrist, including brain tumor, multiple sclerosis, Guillian Barre' syndrome, peripheral neuropathy, porphyria, Alzheimer's disease,

and others. Many good papers have been written on the subject cautioning the psychiatrist to be on the alert for somatic as well as emotional or mental illness.

In summary, a good psychiatrist should not divorce himself from medicine or from medical orientation, lest he overlook an obscure somatic disease. And a good psychiatric examination should be carried out to include the classical topics so that a complete picture may be had of the patient, but not dogmatically to the exclusion of the spontaneous productivity of the patient. Remember that the patient can often give you all but the diagnosis, if you will give him the chance.

FINAL "KINTNER" REGULATIONS DISAPPOINTING

THE LONG AWAITED Regulations for "Kintner" type associations have now been issued in final form by the Internal Revenue Service. Physicians who looked forward to qualifying for tax-deferred pensions plans through the establishment of unincorporated medical groups taxable as corporations will, in most instances, be disappointed.

In the *Kintner* and *Galt* case, it was held that even though under local laws doctors and other professional persons cannot form a corporation, these laws do not necessarily prevent an association of doctors from being taxed as a corporation under the Internal Revenue Code. The court in each case held that the clinic involved more nearly resembled a corporation than a partnership and, therefore, the physicians in the group could participate in a tax-deferred pension plan.

It was hoped that the Regulations would implement the holdings in the *Kintner* and *Galt* decisions. However, in the opinion of the A.M.A. Law Department, the Regulations amount to non-acquiescence on the part of the Commissioner.

The Regulations state that an unincorporated organization shall not be classified as an association unless it has more corporate than noncorporate characteristics. The extent to which the following corporated characteristics are present or absent will determine whether an organization will be classified as a partnership or an association: (1) continuity of life, (2) centralization of management, (3) limitation of liability for debts to organization property, that is, no personal liability on the part of members, and (4) free transferability of interests.

The Regulations provide further that, "The tests, or standards, which are to be applied in determining the the classification in which an organization belongs . . . are determined under the Internal Revenue Code." Although the characteristics or "tests" are listed in the Regulations, it is clear that whether they are met is *not* determined by the Code but by local law:

1. *Continuity of life* is to be determined under local

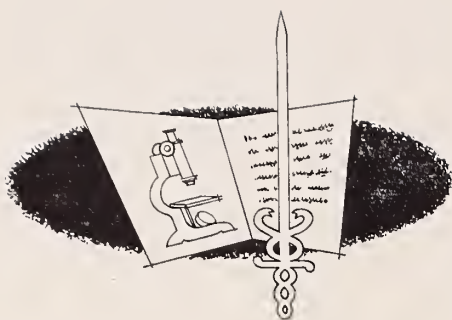
law, and regardless of the terms of the organization agreement, if, under local law, any member can dissolve the organization, continuity of life is lacking. Therefore, according to specific provision in the Regulations, a medical or other group subject to a statute corresponding to the Uniform Partnership Act and a limited partnership subject to a statute corresponding to the Uniform Limited Partnership Act both lack continuity of life.

2. *Centralization of management* cannot be achieved, under the Regulations, by a general partnership subject to a law corresponding to the Uniform Partnership Act. A limited partnership subject to a statute corresponding to the Uniform Limited Partnership Act generally does not have centralized management.

3. *Limited liability* does not exist if under local law a member of an organization remains liable to creditors despite the fact that he enters into an agreement under which another person, whether or not a member of the organization, assumes the liability or agrees to indemnify the member for such liability.

4. *Free transferability* of interests exists if members have the power, without the consent of other members, to transfer their interest to another person who is not a member of the organization. Free transferability does not exist if under local law a transfer of a member's interest results in the dissolution of the old organization and the formation of a new organization.

Prior to the final adoption of the Regulations, the A.M.A. voiced objections with the Commissioner that the determinations to be made under local law were contrary to United States Supreme Court precedents. If local law had been controlling in the *Kintner* and *Galt* cases it is improbable that the decisions would have been the same. Generally, physicians in group practice are regarded as members of partnerships under local law, and, in the absence of a special state statute, a strict application of the Regulations will deny the corporate tax classification to medical groups.



cancer page

ADVANCED CARCINOMA AND ANESTHESIOLOGY

Lester Rumble, Jr., M.D., *Atlanta*

THE PRESENCE OF ADVANCED carcinoma in the human organism merely accentuates the problems ordinarily encountered in anesthesiology. The primary cause for this is the debilitation that results from widespread malignant disease. The result is usually a poor nutritional state coupled with a lowered blood volume and anemia. Many of the reserve mechanisms in the respiratory and cardiovascular systems are already taxed to the breaking point prior to surgical intervention. Thus, the first concern in these individuals is to assess, as accurately as possible, the status of the cardiovascular and respiratory mechanisms. Of equal importance is the determination of electrolyte status, since these elements are commonly deranged. Corrective measures must be instituted, not on the day before surgery, but over a three to five day period (or longer), if anesthesia is to be considered at its safest level.

Transfusions to correct anemia or blood volume deficiencies are not as effective given on the day before surgery as they are if given daily for four or five days prior to operation. The electrolyte picture can be changed rapidly, but more effective readjustment takes place, if this also can be accomplished over a 72-hour period or longer. Intravenous medication serves poorly as a complete substitute

for normal digestive processes and, if possible, a period of normal feeding should precede surgical intervention.

Naturally, when intestinal obstruction complicates the picture, time cannot always be devoted to the above. Corrective measures should be instituted at the start of surgery and continued in the postoperative period.

Some "accidents" are prone to occur in patients with advanced carcinoma. The adrenal glands, either from continued stress or metastasis, may fail to meet the increased demands of anesthesia and surgery. Some patients will not tolerate the induction of anesthesia without cardiovascular collapse. Extreme care in dosage must be exercised and anesthesia maintained in the lightest possible plane. Spinal anesthesia, primarily because of its effects on sympathetic innervation with subsequent hypotension, is a less desirable choice of anesthesia than a well administered general anesthetic.

Special considerations arise in extensive carcinoma about the head and neck. Whereas tracheotomy is many times reserved until the indications are concrete, in these patients the indication for the performance of tracheostomy is present when the first suggestion of its possible need arises. Some of these

Approved by Professional Education Committee, Georgia Division, ACS.

patients present impossible situations when intubation is attempted, particularly when oral tumors are encountered. Preparation for tracheostomy should be made whenever this situation is anticipated. Many airway problems, with their subsequent damaging stress can be avoided, if tracheostomy is performed preoperatively.

The number of chronic alcoholics in the group of patients with carcinoma of the head and neck has become gradually more impressive. The resort to alcohol stems from both the realization of the nature of their disease and from an attempt to relieve the pain which so often accompanies carcinoma in this location. Many patients do well during their first operation, then return for further surgery six months later in a many times unrecognized state of chronic alcoholism. Two such patients recently succumbed to postoperative delirium tremens when alcoholism had not been suspected. In any patient with intractable, constant pain, it is worthwhile to investigate the possibility of alcoholism and assure abstinence for several days preoperatively in order to avoid the development of delirium tremens in the postoperative period.

Probably the most perplexing problem associated with advanced carcinoma is the management of pain. These patients rapidly become dependent on large

doses of narcotics and quite frequently the effects of the narcotic leave the patient in a state of total disability. Rhizotomy or cordotomy have offered some solution to these problems. Over the past ten years some refinements have been made in the use of alcohol as a nerve blocking agent to produce prolonged pain relief. To a limited extent, subarachnoid alcohol can replace surgery in providing pain relief. Consideration of its use should be given in preference to subjecting the patient to a rather major surgical procedure directed only at pain relief. All subarachnoid alcohol blocks must be performed only in a properly equipped hospital and cannot be performed safely on an out-patient basis. These blocks are particularly effective in managing pelvic pain, though not without the possibility of motor dysfunction.

Each year, advances in anesthesiology make it possible to carry out more and more extensive surgical attempts to eradicate cancer. Certainly, the task is easier if surgery is performed early in the stages of the disease before the above mentioned changes have taken place. With earlier diagnosis of this disease, the problem of advanced carcinomatosis is gradually dwindling, but efforts still need to be made toward more effective pain relief when complete eradication of the disease is impossible.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Barker, George W., Jr.	St. Marys Clinic St. Marys	Active	Camden- Charlton
Harper, Clarence H.	503 3rd St. Folkston	Active	Camden- Charlton
Jackson, Joseph M.	Folkston	Active	Camden- Charlton
Edward S. Lundell	Folkston	Active	Camden- Charlton
McCollum, R. Roy, Sr.	Box 356 Kingsland	Active	Camden- Charlton
Pritchard, William Lee	Talmadge Mem. Hosp. Augusta	DE-2	Richmond
Robinson, Harry H., Jr.	Kingsland	Active	Camden- Charlton
Simmons, J. O.	Drawer 247 Woodbine	Active	Camden- Charlton
Stubbs, R. E.	505 Osborne St. St. Marys	Active	Camden- Charlton



the association

DEATHS

ESTER LEANDER EVANS, 68, who practiced medicine in Tifton for many years, died December 2 at a hospital in Dublin.

Dr. Evans had been living in Tallahassee, Fla., since August, 1960, until he moved to Dublin recently. He moved to Tifton from Perry in 1929 and practiced medicine there until ill health forced his retirement a few years ago.

He was a graduate of Emory University School of Medicine, a member of the Tifton Methodist Church, member of the American Legion and was first post commander at Perry, and was past president of the Tifton Kiwanis Club.

Survivors included a daughter, Mrs. W. F. Trawick, Tallahassee, Fla.; two sisters, Mrs. William Starling, Walnut Grove, Miss. and Mrs. Bertress Strickland, Kasciusko, Miss., and four grandchildren.

CHARLES A. HODGES, former mayor of Dublin, died December 24 in a hospital in Dublin at the age of 74.

Dr. Hodges was a native of Washington County and served as a first lieutenant during World War I.

As an eye, ear, and nose specialist, he had only recently retired from active practice. He was a Mason, a member of the Laurens County Medical Society, and other civic groups. Lately his chief interest had been participating in the realization of the new sanctuary for the First Christian Church, of which he was a member and trustee.

Survivors include his wife, the former Miss Annie Belle Williamson; two sons, Dr. Charles A. Hodges, Jr., Augusta, and Robert Earl Hodges, Macon; three daughters, Mrs. Murray A. Chappell, Dublin, Mrs. C. T. Alexander, Augusta, and Mrs. L. G. Callahan, Ann Arbor, Mich.; one brother, R. T. Hodges, of Montrose; two sisters, Mrs. H. L. King, Kingsland, and Mrs. Lula Bell, of Kingston, N. Y.; 15 grandchildren, and one great-grandchild.

LEE HOWARD, SR. prominent Savannah physician and head of the Howard Clinical Laboratory, died unexpectedly at his residence December 14 at the age of 72.

Dr. Howard was a graduate of Mercer University in 1909, Johns Hopkins Medical School in 1913, and had

done graduate work at Johns Hopkins. He was resident physician at Telfair Hospital in Savannah from 1915-1917.

The well known pathologist, beginning in 1929, had organized and directed clinical laboratories in every Savannah hospital. He formed a partnership with his son, Dr. Lee Howard, Jr., in 1945.

Active in state medical affairs, he was president of the Medical Association of Georgia in 1959 and counsellor of the First District of the society for many years, serving as First District president in 1934.

In 1959 he was asked by Gov. S. Ernest Vandiver to name a five-man committee from the Medical Association to study the professional standards and practices in the care of mental patients at Milledgeville State Hospital.

During 1946 and 1947, Dr. Howard organized the Savannah Tumor Clinic, Inc., which has operated the State Aid Clinic and the therapeutic clinic since that time. He was one of the original incorporators of the clinic and had served on the board of directors.

A director of the Savannah Cancer Clinic since 1938, Dr. Howard was a member on the board of directors and vice counsellor of the Chatham County unit of the American Cancer Society.

He was president of the Chatham-Savannah Health Council in 1945-46 and during that time the council, then known as the Savannah Health Center, was reorganized into its present form.

Dr. Howard served as president of the Georgia Medical Society in 1930-31 and was active on the board of trustees from 1931-35. He was secretary-treasurer for a number of years prior to 1955.

The physician's hospital staff appointments have included consultant pathologist to the Chatham County Memorial Hospital, the Bulloch County Hospital in Statesboro, and the Emanuel County Hospital in Swainsboro and pathologist to the Telfair Hospital, Central of Georgia Hospital, Oglethorpe Sanatorium, and the Georgia Infirmary.

In 1951, Dr. Howard established at Telfair Hospital the first clinical laboratory in South Georgia. It has been in continuous operation since that time.

His war service included serving as a first lieutenant, Medical Corps, 1918-19 at General Hospital, Ft. Oglethorpe, Ga., where he was chief of urological service and director of clinical laboratory. He was a surgeon

and director of the laboratory of the U. S. Marine Hospital from 1920-50, when optional retirement was obtained.

Dr. Howard was appointed a member of the First District advisory board during World Wars I and II and in 1940 was clinical pathologist to the First District medical advisory board in charge of the blood program.

He was a fellow of the American College of Physicians, 1930-36; fellow of the American Society of Clinical Pathologists from 1936 to the present time, and fellow of the College of American Pathologists since 1955.

Dr. Howard was a charter member of the Kiwanis Club and a member of the Men's Garden Club of Savannah.

Survivors include his wife, May duBignon Stiles Howard; four sons, Dr. John C. Howard, Dr. Lee Howard, Jr., Harry D. Howard, all of Savannah, and Dr. Robert M. Howard, of Youngstown, Ohio; a daughter, Mrs. A. L. Zipperer, Greenville, S. C.; a sister, Mrs. Barney D. Lamar, of Augusta, and 17 grandchildren.

JABEZ JONES, 87, of Savannah, died December 31 at a hospital in Savannah.

Acclaimed as the inventor of bolts for joining broken bones, Dr. Jones was chief of staff of the Telfair Hospital for 33 years.

A pioneer in bone surgery, he was one of the first members of the American College of Surgeons. During his career, he also developed an orthopedic table.

Dr. Jones, a native of Madison, S. C., was surgeon for the Seaboard Air Line Railroad and for the Southern Cotton Oil Co. for a number of years.

He had served as president of the Georgia Medical Society, Savannah Benevolent Association, and Seaboard Medical Association.

Survivors include his wife, Mrs. Fanny May Tibbs Jones, Savannah; a son, Spencer Calhoun Jones, New York, N. Y., and a grandson.

SPENCER ATKINSON KIRKLAND, a urologist in Atlanta for about 40 years, died at his home December 29 at the age of 71.

A native of Pearson, Dr. Kirkland had lived in Atlanta about 50 years. He was a graduate of Emory University and Emory University School of Medicine. His internship was completed at Grady Memorial Hospital.

He was a member of the Peachtree Road Methodist Church, the Shrine, the Capital City Club, the Fulton County Medical Society, the Medical Association of Georgia, and was a fellow in the International College of Surgeons. He served many terms as Delegate to the Medical Association of Georgia; served two terms as Delegate to the American Medical Association, and was formerly on the Editorial Board of the Medical Association of Georgia. He received a distinguished citation as member of the Committee on Legislation, 1948 to 1954, for supporting medical matters of statewide importance.

Dr. Kirkland was a veteran of World War I, when he served in the Medical Corps of the 82nd Division. He was a past president of the staff of the Crawford

W. Long Memorial Hospital and was a former member of the State Board of Health.

Survivors include his wife, the former Nelle Fielder; a daughter, Mrs. Robert A. Blackwood, Atlanta; a brother, Dr. W. P. Kirkland, Manchester, and two grandchildren.

MILLARD E. WINCHESTER, district public health director for Glynn, Camden, and McIntosh counties and one of the nation's outstanding public health figures, died at the age of 67 December 24 at a hospital in Atlanta.

Born at Flint, Dr. Winchester was a student at Riverside Military Academy at Gainesville, 1911-12, and received his doctorate in medicine from Emory University in 1917. He was a student at Johns Hopkins School of Hygiene and Public Health in 1925-26.

Dr. Winchester received an honorary bachelor of public health degree from the University of Georgia in 1924 and was proclaimed doctor of public health by the University in 1925.

Last year, Dr. Winchester was honored for his pioneering efforts in venereal disease control and his continuing efforts to eradicate it. He was made an honorary life member of the American Social Health Association and presented with a citation in Atlanta by Dr. R. A. Vonderlehr, retired assistant surgeon general of the U. S. Public Health Service.

His career as a public health official began in 1923, having served as a general practitioner from 1917 until then. He became commissioner of public health in Thomas County in 1923 and director of county health work for the Georgia State Department of Public Health in 1926.

In 1934, he left the State Health Department to accept the post of commissioner of public health in Glynn County. He had served as a special consultant for the U. S. Public Health Service since 1937 and was named executive administrator of the Brunswick City Hospital in 1949.

Dr. Winchester was a diplomat, American Board of Preventive Medicine and Public Health; a fellow in the American College of Physicians, American Health Association, and a member of the American Medical Association, Southern Medical Association, Tropical Medical Society, and the American School of Physicians Association.

He was also president of the Glynn County Medical Society and the Georgia Public Health Association, and a member of the Theta Kappa Psi Fraternity, the Elks, and the Brunswick County Club.

Survivors include his wife, the former Ruth Evelyn Dixon; a daughter, Mrs. William T. Jones, Atlanta; two grandchildren, and two great-grandchildren.

SOCIETIES

A stroke clinic, sponsored by the BALDWIN COUNTY MEDICAL SOCIETY and the Heart Coun-

cil. was held just before Christmas in the Baldwin County Hospital.

Jule C. Neal, of Macon, has been installed as new president of the BIBB COUNTY MEDICAL SOCIETY. Other 1961 officers include William R. Birdsong, president-elect; Lon King, Jr., vice president; John T. Dupree, secretary; A. M. Phillips, parliamentarian, and William E. Pound, Board of Health representative.

The new officers for the CARROLL-DOUGLASHARALSON COUNTY MEDICAL SOCIETY are: W. Steve Worthy, president; Martin L. Johnson, president-elect, and J. H. Beall, secretary-treasurer, all of Carrollton.

The DOUGHERTY COUNTY MEDICAL SOCIETY and the Georgia Academy of General Practice sponsored a seminar February 23 in Albany. The seminar was organized by the Department of Continuing Education at the Medical College of Georgia.

The new officers for the GEORGIA MEDICAL SOCIETY for 1961 were elected at the Society's December meeting. They are: T. A. Peterson, president; John Kirk Train, Jr., president-elect; David B. Fillingim, vice president; Jeff J. Holloman, secretary, and J. J. Doolan, Jr., treasurer.

Members of the SPALDING COUNTY MEDICAL SOCIETY and its Auxiliary held their annual Christmas Party at the Elks Club in Griffin.

In December at a joint meeting of the STEPHENS COUNTY MEDICAL SOCIETY and the Stephens County Hospital Staff, Dr. William Hopkins of Atlanta spoke to the group on chronic pulmonary diseases and demonstrated several new pieces of equipment now available in treating these diseases.

Leading physicians and heart specialists from throughout Georgia discussed various methods of treatment for rheumatic heart diseases as the THOMAS-BROOKS COUNTY MEDICAL SOCIETY conducted a symposium recently in Thomasville.

Paul Lucas, of Tifton, was elected 1961 president of the TIFT COUNTY MEDICAL SOCIETY in December. Other officers elected were Robert Jones, vice president and Tom Edmondson, secretary-treasurer.

At the December meeting of the TRI-COUNTY MEDICAL SOCIETY, composed of Franklin Hart, and Elbert counties, R. E. Ridgway, of Royston, was elected president of the Society along with Hubert Milford, Hartwell, vice president, and Jack B. Hanks, Elberton, secretary-treasurer.

The new officers of the TROUP COUNTY MEDICAL SOCIETY, elected at the Society's regular meeting in December, are Curran S. Easley, Jr., president; J. R. Turner, vice president, and J. T. Mitchell, secretary-treasurer, all of LaGrange.

Neal F. Yeomans, Waycross, has assumed leadership of the WARE COUNTY MEDICAL SOCIETY. Officers named to serve with him are: Malcolm McGoogan, vice president and H. T. Adkins, secretary-treasurer. The Society held its regular January meeting at the Okefenokee Golf Club.

THE FIRST DISTRICT MEDICAL ASSOCIATION entertained the legislators and their wives from the First District of Georgia at the Forest Heights County Club in December. The guest of honor was Lt. Governor Garland T. Byrd. All of the First District legislators and their wives were invited as were several member of the Georgia Dental Association and their wives.

PERSONALS

First District

June, 1961, will be the date that JOHN D. McARTHUR will return to Lyons to be associated as a partner in the operation of the Aiken Hospital.

Having practiced in Savannah for the past seven years, BENJAMIN C. WILLS has been certified as a diplomate by the American Board of Neurology and Psychiatry.

Second District

When J. A. REDFEARN closed his office at the end of 1960 and announced he was retiring from the active practice of medicine, he brought to a close a professional career that extended over a half century, all of it spent in Albany.

Together with some 20 other physicians from southeastern states, EDWARD S. ARMSTRONG, Albany, discussed the clinical and basic biochemical aspects of diabetes at a workshop concerned with diabetes held at the Medical College of Georgia in Augusta recently.

The executive director of the American Academy of Pediatrics announced recently that WILLIAM LEE BRIDGES, JR., Tifton, has been elected a fellow of the Academy.

Seven employees of the Georgia Department of Public Health, one being C. W. HARWELL, Moultrie, were honored for their 25 years of service at ceremonies in Atlanta in December.

Three Sylvester men were among a group which recently attended a planning session for a tuberculosis control program in the Republic of Haiti, one being NORMAN J. CROWE. The meeting was held at Port Au Prince.

Third District

ROBERT B. MARTIN, III, Cuthbert, recently participated in a postgraduate course concerned with fractures in general practice held at the Medical College of Georgia in Augusta.

The new president of the medical staff of the Americus and Sumter County Hospital is ENNIS W. WALDEMAYER, Americus. He succeeds T. SCHLEY GATEWOOD, Americus.

For the first time in the history of Marion County, they will be without a doctor. ROBERT S. ROBINSON, formerly of Buena Vista, has moved to Metter to form a partnership with a former classmate, ROBERT L. PENCE.

At a recent workshop concerned with diabetes held at the Medical College of Georgia in Augusta, WILL-

IAM G. CHAMBLESS, Hamilton, along with some 20 other physicians from southeastern states, discussed the clinical and basic biochemical aspects of diabetes.

Fourth District

A Thomaston physician, R. J. MINCEY, has announced that he will close his medical practice to return to medical studies. He has accepted a two-year residency in anesthesiology at Grady Memorial Hospital in Atlanta.

Fifth District

During the 56th anniversary banquet of the Fulton County Medical Society held at the Piedmont Driving Club in Atlanta in January, A. HAMLIN LETTON, Atlanta, was given the Aven Citizenship Award as the doctor contributing most to civic affairs during the preceding year.

The opening session of the Georgia Association of School Counselors was addressed by RIVES CHALMERS, Atlanta. The meeting was held in December at the Atlanta YMCA.

DAVID L. HEARIN, Atlanta, has moved his office for the practice of dermatology to 3158 Maple Drive, N.E.

At a recent meeting of the Post Admission Education Program of the Atlanta Bar Association held at the Atlanta Athletic Club, CHARLES S. JONES, Atlanta, addressed the group, his topic being "Medico-Legal Relationships."

Sixth District

H. LUMPKIN COFFEE, Forsyth, and WILLIAM RAWLINGS, Sandersville, recently participated in a postgraduate course concerned with fractures in general practice held at the Medical College of Georgia in Augusta.

The current vice president of the Parkview Hospital, CHARLES R. IRELAND, Macon, has been named to serve as president of the hospital in 1961.

Seventh District

The new chairman of the board of the Marietta Hospital is R. P. COGGINS, Marietta.

C. V. VANSANT, SR. and C. V. VANSANT, JR., of Douglasville, have moved to their office building on Church Street.

At the annual election of officers of the medical staff of Hamilton Memorial Hospital, ALBERT M. BOOZER, Dalton, was elected president for 1961.

Eighth District

At a recent Regional Meeting of the American College of Physicians held at Ponte Vedre Beach, Fla., EMANUEL A. DANEMAN, Waycross, presented a paper to the group. Dr. Daneman has also accepted an invitation to be secretary of a session on "Papers on Clinical Psychiatry" at the annual meeting of the American Psychiatric Association in Chicago this May.

I. S. GIDDENS, Lakeland, and RALPH ROBERTS, Fitzgerald, recently participated in a postgraduate course concerned with fractures in general practice held at the Medical College of Georgia in Augusta.

The Nahunta High and Grammar School combined PTA meeting held in January, had as their speaker A. M. KNIGHT, JR., Waycross. IVEY JACOBS, also

of Waycross, spoke at the January meeting of the Hoboken PTA.

The speaker for the January meeting of the Hortense PTA was R. E. MILLER, of Jesup.

Ninth District

W. BRUCE SCHAEFER, Toccoa, was sworn in recently as a member of the Stephens County Board of Roads and Revenues by Judge Lamar N. Smith, succeeding ROBERT E. SHIFLET, Toccoa, who resigned. Dr. Schaefer will fill the unexpired term of the former Commissioner, whose term expires Jan. 1, 1962.

Among those that recently attended a three-day workshop on diabetes at the Medical College of Georgia in Augusta were JAMES C. DUDLEY, JR., Toccoa, and WESLEY W. HARRIS, Royston.

Dr. Bruce Swain is now associated in practice with D. H. GARRISON, of Clarkesville.

Tenth District

Instructors from the Medical College of Georgia in Augusta that recently participated in the three-day workshop on diabetes held at the Medical College were: JOHN W. KEMBLE, HARRY T. HARPER, JR., JOHN R. FAIR, and THOMAS FINDLEY.

B. SHANNON GALLAHER, Augusta, has opened her office for the practice of internal medicine and diseases of the chest at 1445 Harper Street.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING MINUTES

THE MEETING OF THE Council of the Medical Association of Georgia was called to order by Council Chairman J. G. McDaniel at 9:05 A.M., December 11, 1960, at the MAG Headquarters Building, Atlanta, Georgia.

Council members present in addition to Chairman McDaniel were: Milford B. Hatcher, Macon, President; Fred H. Simon-ton, Chickamauga, President-Elect; Luther H. Wolff, M.D., Immediate Past President; Simone Brocato, Columbus, First Vice President; Braswell E. Collins, Macon, Second Vice President; John T. Mauldin, Atlanta, Secretary; Thomas W. Goodwin, Augusta, Speaker of the House; J. Frank Walker, Atlanta, Vice Speaker of the House; AMA Delegates J. W. Chambers, LaGrange, Eustace A. Allen, Atlanta, and Henry H. Tift, Macon; Councilors: Virgil Williams, Griffin, Fourth District; J. G. McDaniel, Atlanta, Fifth District; George H. Alexander, Forsyth, Sixth District; Ralph W. Fowler, Marietta, Seventh District; F. G. Eldridge, Valdosta, Eighth District; C. R. Andrews, Canton, Ninth District; Addison Simpson, Washington, Tenth District; Vice Councilors: J. Z. McDaniel, Albany, Second District and Paul T. Scoggins, Commerce, Ninth District. Also in attendance were: Edgar Woody, Jr., Atlanta, Editor, JMAG; John Bell, Dublin, Chairman, Legislation Committee; John Venable, Atlanta, Director, State Department of Public Health; Harry B. O'Rear, Augusta, President, Medical College of Georgia; Samuel U. Braly, Dallas, State Senator; D. N. Thompson, Elberton, State Board of Health; Lester Petrie, Atlanta, State Department of Public Health; David R. Thomas, Augusta, Chairman, Insurance and Economics Committee; Mr. Edwin Swain, Director, State Merit System; Mr. John Moore, Attorney; Mr. Milton D. Krueger, Executive Secretary; Mr. John F. Kiser, Associate Executive Secretary; Mr. Frantz Lipsey, Medicare Administrator, and Mrs. Catherine Wooten, Executive Assistant.

Chairman McDaniel called on Mr. Krueger to read the minutes of the Council meetings October 1-2 and October 23 and Executive Committee of Council meetings October 2, October

23, and November 5, 1960. There being no corrections, on motion duly made and seconded, the minutes were then approved.

Medical Education Plan

Harry O'Rear, President of the Medical College of Georgia, asked for the support of MAG in meeting the increasing needs for faculty in medical and dental schools and nursing facilities. Dr. O'Rear stated provisions were being made to plan for the increase of students. Dr. Hatcher stated that MAG should back this plan and presented a Resolution as follows:

"Whereas, higher levels of education are needed to maintain and accelerate Georgia's recent industrial, agricultural, and medical care gains, and

Whereas, quality education for the growing college age population will require greatly increased faculties and facilities, throwing an enormous financial burden on the colleges and universities, and

Whereas, professional education in the fields of medicine, dentistry, nursing, and allied fields is an integral part of higher education and of special concern to the medical profession in its objective of better health for the people of the State of Georgia.

Now, therefore, be it resolved that the Council of the Medical Association of Georgia recognizes the need of increased financial aid for higher education and through official publications and pronouncements of its officers and staff and individual members will proclaim its interest and support.

Further, through the Legislative Committee of the Association will lend support to appropriation acts for the University System when such are presented to the General Assembly."

On motion (Wolff-Alexander) this Resolution was approved.

State Employees Physical Examination

Lester Petrie, State Department of Public Health, and Mr. Edwin Swain, Director, State Merit System, gave a report on a recommended plan for an improved program of state employee physical examinations. He stated that pre-employment physical examinations for the state would be done at designated health centers. Local physicians would be selected to help with these examinations, with fee for service to be determined later. There was general discussion following the report. On motion duly made and seconded, it was voted to refer this matter to the Industrial Health Committee for report to the next Executive Committee meeting.

Governor's Study Committee Report and Discussion

John Venable, Director, State Department of Health, discussed implementation of the Kerr-Mills Bill. John Mauldin and J. W. Chambers discussed this further. On motion (Alexander-Allen) it was voted that Council go on record as reaffirming its position as expressed in a resolution adopted July 23, 1960 in Macon.

Medicare Review Board Recommendations and Contract Renewals

Mr. Lipsey gave a report on renegotiation of the MAG-Department of Army Medicare contract. He asked Council's approval on six proposals:

(1) Recommended change in the policy concerning the billing for drugs. Approved by Council.

(2) Recommended change concerning the policy of new born care rendered by the delivering physician. Approved by Council.

(3) Recommended change in billing procedure for new born care rendered by pediatricians. Rejected in entirety by Council.

(4) Recommendations concerning term of office for Review Board Chairmen. Approved by Council.

(5) Recommendations concerning cases with more than one physician. Rejected by Council, but administrative measure to be taken to correct.

(6) Recommendations concerning state Medicare Review Board meetings. Approved by Council.

On motion duly made and seconded it was voted to renegotiate the contract.

AMA Relative Value Meeting Report

After discussion of relative value schedules, on motion (Hatcher-Simonton) it was voted to appoint a committee to study this subject.

Rehabilitation Committee Booklet

Mr. Krueger gave a report for Dr. Bennett, Rehabilitation Committee Chairman, concerning a proposed booklet for publication. As no action was requested the report was accepted for information.

Designation of AMA Delegation Chairman

On motion (Allen-Collins) it was voted to designate Henry Tift as Chairman for 1961.

Legislative Committee Report

John Bell, Chairman, gave a report of the November 9, 1960 committee meeting. This was accepted for information.

Pension Budget Request

Finance Committee Chairman Virgil Williams read a letter from Spalding County regarding one of their pensioners, with the request for matching by MAG. On motion (Hatcher-Collins) it was voted to approve the matching with MAG funds.

Annual Session Budget Request

Henry Tift, Annual Session Chairman, asked for an additional \$150.00 to defray expenses of sending Commercial Exhibits Chairman to Medical Exhibitors Association annual meeting. This item had been inadvertently omitted in his original budget request. On motion duly made and seconded it was voted to approve the extra amount and so change the 1961 budget.

Interprofessional Code

Mr. Krueger gave a report and requested an additional \$85.00 as MAG's share of the expense in publishing the Code. The amount of \$250.00 had been budgeted but \$335.00 was needed, or an additional \$85.00. On motion (Mauldin-Allen) it was voted to make these funds available.

Committee Reorganization Report

Secretary Mauldin gave this report in Chairman George Dillinger's absence. On motion (Hatcher-Simonton) it was voted to accept this report in principle, but to refer it to the Constitution and Bylaws Committee for consideration.

Investment of MAG Funds

In Treasurer Arp's absence Dr. Williams gave the report. On motion duly made and seconded it was voted to refer this to the Executive Committee for action in January.

AMA Delegates Report

Delegate J. W. Chambers gave the report, which was received for information. He asked permission of Council to write each member of the AMA House of Delegates re the intention of the MAG to place Eustace A. Allen's name in nomination for the position of Vice President of the American Medical Association. On motion (Alexander-Mauldin) it was voted that Council endorses and supports this recommendation.

AMA Activity Report

Mr. Charles Johnson, AMA Field Representative, reviewed legislative activities. This was received for information.

Headquarters Office Report

Mr. Krueger gave a report for information. He announced that Mr. John Kiser, Associate Executive Secretary, has tendered his resignation, effective February 1, 1961, to go with AMA as a Field Representative. Mr. Kiser then formally submitted his resignation to Council. On motion (Hatcher-McDaniel) it was voted to accept his resignation with regret and best wishes for his future.

A. H. Robins Award

Mr. Krueger read a letter from the A. H. Robins Company re the Robins Award for community service by a physician. On motion (Tift-Walker) it was voted to table the idea at this time.

Other Business

(1) *Letter of Recommendation David Henry Poer:* Chairman McDaniel announced that he had been informed that Dr. Poer was being considered as Assistant Secretary of Defense in Charge of Health. On motion (Fowler-Hatcher) it was voted to endorse Dr. Poer for this position and Chairman McDaniel was instructed to write the letter of recommendation.

(2) *Letter of Commendation for Dr. Heard:* It was recommended that Secretary Mauldin write a letter of commendation to Dr. Heard for the work done on the Annual County Society Officers Conference held at the Dinkler Plaza Hotel, Atlanta, December 10-11, 1960.

(3) *Date and Site of March Council Meeting:* On motion duly made and seconded, it was voted to have Executive Committee determine the date and site.

There being no further business, the meeting of the MAG Council was adjourned at 3:40 P.M.

SUMMARY — 1960 AND 1961 BUDGET THE MEDICAL ASSOCIATION OF GEORGIA

	1960 Budget	Actual 10 Months Ended Oct. 31, 1960	1961 Budget Tentative
INCOME			
Medical Assn. of Ga. dues	\$ 98,500.00	\$ 99,612.50	\$100,680.00
Interest and AMA refund	500.00	1,049.13	800.00
GAGP Secretarial Service	2,820.00	2,350.00	2,820.00
Total Income	\$101,820.00	\$103,011.63	\$104,300.00

EXPENSES

I Fixed Allotments.....	\$ 11,300.00	\$ 5,988.72	\$ 10,300.00
II Association Office	59,607.50	39,995.71	68,073.00
III MAG Committees..	23,860.00	15,476.19	14,550.00
IV MAG Annual Session	2,600.00	1,900.00	190.00
V JMAG Publication	2,902.50	(4,406.63)	2,133.25
VI Contingencies	6,550.00	5,819.33	—
Total Expenses	\$106,820.00	\$ 64,773.32	\$ 95,246.25

BUDGET INCOME — (LOSS) \$ (5,000.00) \$ 38,238.31 \$ 9,053.75

Payment due on mortgage on or before Jan. 1
(not budgeted) 4,000.00
5% interest

LIQUID FUNDS AVAILABLE

	Dec. 31, 1959	Oct. 31, 1960
Cash in bank.....	\$ 435.74	\$ 17,791.91
U. S. Government securities	12,560.00	12,560.00
Total	\$ 12,995.74	\$ 30,351.91

CAPITAL IMPROVEMENTS TO BUILDING

.....\$ -0- \$ 14,086.55

MEDICAL ASSOCIATION OF GEORGIA EXECUTIVE COMMITTEE OF COUNCIL

THE DECEMBER MEETING of the Medical Association of Georgia Executive Committee on Council was called to order by Chairman Milford B. Hatcher at 3:45 P.M. on December 11, 1960 at the MAG Headquarters Building, Atlanta, Georgia.

The members of the Committee present were: Milford B. Hatcher, Macon, President and Chairman; Fred H. Simonton, Chickamauga, President Elect; Luther H. Wolff, Columbus, Immediate Past President; J. G. McDaniel, Atlanta, Chairman of Council; John T. Mauldin, Atlanta, Secretary, and Virgil B. Williams, Griffin, Chairman of Finance. Also present were Mr. Milton D. Krueger, Executive Secretary and Mrs. Catherine Wooten, Executive Assistant.

Headquarters Office Personnel and Property Insurance

Dr. Hatcher read a report of an investigation of the MAG office and personnel insurance. Changes were suggested as follows:

(1) Installation of Workmen's Compensation for MAG employees: On motion (Wolff-McDaniel) it was voted to have the Secretary proceed with installation of this program.

(2) Additional liability insurance was recommended: On motion duly made and seconded it was voted to have the Secretary find out how much additional a lower deductible limit would cost. Bids were to be obtained from several companies.

American Physical Therapy Association Request

Mr. Krueger read a letter from the Physical Therapy Association. The Executive Secretary was instructed to write the Physical Therapy Association that the Executive Committee looks with favor on their proposal, but are in the course of a plan of committee reorganization and will inform them later as to the MAG provision for such a liaison committee.

MAG Service Membership

Dr. Mauldin read a plan suggested by the MAG attorney regarding status of Service Members. On motion (Simonton-Hatcher) it was voted to send this to the Constitution and Bylaws Committee for study.

Office Equipment Letter

On motion duly made and seconded it was voted not to purchase the letter stuffing machine for the Headquarters office.

Sixth District Recommendation

Mr. Krueger read a letter from Herbert M. Olnick re: MAG budgeting money for district meetings. Executive Committee feels that it should be handled as before, as the budget will not allow the additional expense.

Other Business

(1) *Workmen's Compensation Fee Schedule*—Letter received asking that MAG appoint a committee to study and recommend revision of the fee schedule. It was recommended that this be referred to T. A. Peterson, Chairman, Industrial Health Committee. Secretary Mauldin was asked to write Dr. Peterson and send Dr. Hailey's letter.

(2) *List of Inactive Committees*—President Hatcher asked the Secretary to send him a list of the committees who have been inactive in the past year.

(3) *Date and Site of January Executive Committee Meeting*—On motion duly made and seconded it was decided to hold the meeting on January 22, 1961 in Atlanta.

There being no further business the meeting was adjourned at 4:30 P.M.

DR. WILLIAM F. HAMILTON HONORED

DR. WILLIAM F. HAMILTON, professor emeritus of physiology at the Medical College of Georgia, was one of 10 leaders of American medicine honored on Janu-

ary 9 for contributions which have directly influenced medical progress in the United States.

Recipients of the Distinguished Achievement Awards

were selected by the Editorial Board of *Modern Medicine*, international medical journal, from nominations by deans of medical schools, leaders of professional medical organizations, and readers of the journal.

Dr. Hamilton, 67, was specifically cited for his work in cardiovascular physiology and pathology that laid the basis for cardiac surgery. He gained international reputation for developing an effective means of measuring the output of the heart and for a device known as the Hamilton manometer, the earliest device used to record the details of human arterial pressure pulse by means of a simple needle.

With the diagnostic procedures made possible by Hamilton's work, the cardiac surgeon has a more definite knowledge of the location of a defect causing congenital heart disease and how the defect can be mended.

After receiving his bachelor's degree from Pomona College and his doctorate from the University of California, Dr. Hamilton began research on the indicator dilution method at the University of Louisville in 1925 and continued the project at the Medical College of Georgia in the early 1930's. In 1947, a Georgia and a Columbia University team proved that the results of Hamilton's method were the same as those produced by Cournand and Richards, Nobel Prize Winners, and the rather tedious methods of analysis in use at the time were supplanted by rapid automatic technics. The indicator dilution method has become standard procedure in many medical centers.

Described by his associates as "a stimulator but not a slave driver," Dr. Hamilton is a lecturer and author of numerous papers. In 1958, the American Heart Association bestowed on him its most coveted award, the Gold Heart Award, and in 1960 he received the Distinguished Achievement Award of the Georgia Heart Association.

Other award winners are:

David P. Barr, M.D., 71, currently president and medical director of the Health Insurance Plan of

Greater New York, for his contributions in the fields of parathyroid disease and atherosclerosis and as a teacher of teachers. He recently retired as professor of medicine at Cornell University and as a physician-in-chief at New York Hospital.

Lowel T. Coggeshall, M.D., 59, vice president in charge of medical affairs at the University of Chicago, for his service as an administrator and medical statesman and achievements in tropical medicine.

Julius H. Comroe, Jr., M.D., 49, director of the Cardiovascular Research Institute of the University of California, for leadership in investigation of pulmonary function and clinical use of autonomic drugs.

Frank J. Dixon, Jr., M.D., 40, professor and chairman of the department of pathology at the University of Pittsburgh, for contributions to understanding antibody production and diseases of connective tissue. Dr. Dixon this year will be taking over as director of experimental pathology at the Scripps Clinic and Research Foundation at LaJolla, California.

Rene J. Dubos, Ph.D., 59, Rockefeller Institute for Medical Research, for his fundamental work that helped usher in the era of antibiotics.

Charles A. Hufnagel, M.D., 44, professor of surgery at Georgetown University, for development of surgical technics for treating heart and great vessel disorders.

Severo Ochoa, M.D., 55, professor and chairman of the department of biochemistry at New York University, for his demonstrations of enzyme catalysis, ribonucleic acid biosynthesis, and muscle function.

Marion B. Sulzberger, M.D., 65, chairman of the department and director of the Skin and Cancer Unit of New York University-Bellevue Medical Center, for integration of basic science and clinical dermatology.

George W. Thorn, M.D., 54, physician-in-chief of Peter Bent Brigham Hospital and Hersey professor of the theory and practice of physic (correct) at Harvard, for contributions to the understanding of metabolic disease and stress patterns.

WHITE HOUSE CONFERENCE ON AGING

SPOKESMEN FOR THE MEDICAL profession at the White House Conference on Aging supported the Kerr-Mills voluntary program for health care of elderly persons as an efficient, economical way to furnish assistance to those who need help.

Leading physician delegates to the Conference also continued vigorous opposition to the Social Security approach espoused by organized labor.

Continuing their all-out campaign for the Social Security approach, labor union leaders used the Conference as a forum for further attacks on the medical profession.

Dr. J. Lafe Ludwig of Los Angeles, Chairman of the

American Medical Association Council on Medical Service, told a pre-Conference meeting of the physician delegates that it would be a "national tragedy—unfair to old and young alike—if the Kerr-Mills law should be shelved for a Social Security plan for medical care of the aged.

"Federal medicine would mean red tape, bureaucratic control, and high costs," Dr. Ludwig said. "Most important of all, it would mean inferior medical care for the people whom we are trying to help."

Describing the Kerr-Mills law as a "historic milestone," Dr. Ludwig said the "overwhelming majority" of the nation's physicians believe it is "an excellent

law which can and will work and deserves every opportunity to do so."

Dr. Leonard W. Larson of Bismarck, N. D., president-elect of the A.M.A., told the Conference's Health and Medical Care Section that more attention must be given to keeping older persons healthy. He was chairman of the section.

"We spend millions of dollars and hours developing sound, well-based programs for care of the sick, but at the same time we virtually ignore the vast opportunities for preservation and promotion of health, Dr. Larson said.

"We must do more than react to the minority of older persons who are ill—we must act for the great majority who are well."

In a statement issued in Chicago, Dr. E. Vincent Askey of Los Angeles, President of A.M.A., branded as false an allegation that the White House Conference has been "captured" by organized medicine, private insurance, and business interests. Dr. Askey specifically referred to such a charge made by Prof. Wilbur J. Cohen of the University of Michigan, but the A.M.A. president's statement applied to similar charges made by representatives of organized labor.

Dr. Askey implied that, "if anyone has a legitimate complaint regarding the choice of personnel directing the activities" of the key section on income maintenance, it was opponents of the Social Security approach.

Dr. Ludwig also answered organized labor's attacks on the A.M.A. at the Conference. Dr. Ludwig accused George Meany, president of the AFL-CIO, of "attempting to undermine" the Conference to "further his own partisan interests."

"Meany obviously is prepared to go to any extreme to impugn the motives of those who disagree with him," Dr. Ludwig said. "Delegates to this conference representing medicine and many other groups came here in a spirit of cooperation determined to take realistic action to help the elder citizens of this country.

"Meany, through his campaign of smear and hostility, is making this difficult, if not impossible.

Dr. Ludwig said that some labor leaders "obviously are more interested in saddling the people of this country with a system of socialized medicine" than he is in "helping those older people who really need help."

"Meany and such of his cohorts as Sen. Pat Mc-

Namara (D., Mich.) appear to be doing their utmost to create so much confusion that recommendations of the State Conference on Aging will be forgotten," Dr. Ludwig said.

"Of the 30 states making specific recommendations regarding financing of medical care for the aged, only 10 favored the Social Security tax."

President Eisenhower urged the 2,700 delegates to the Conference to reconcile their differing views and agree on a sound program. He told the delegates it was their responsibility to provide "some kind of guidance for Congress to use in its future deliberations."

President John F. Kennedy declined an invitation to address the Conference as President-elect. He and Congressional Democratic leaders decided weeks before the Conference to make medical care for the aged under Social Security an Administration priority bill for early submission to Congress.

But some key Democrats in Congress announced they would not go along with President Kennedy on the issue. Sen Robert S. Kerr (D., Okla.), co-author of the medical-care-for-the-aged program approved by Congress last year, said it should be financed by a general tax—"not a limited tax like Social Security."

Similar opposition to the Social Security approach was expressed by Sen. John J. Sparkman (D., Ala.). Chairman Harry F. Byrd (D., Va.) of the Senate Finance Committee earlier had said he was convinced that providing medical care for the aged under Social Security would lead to socialized medicine and possibly bankrupt the Social Security trust fund.

Despite the Kennedy Administration's espousal of the Social Security plan, the A.M.A. pledged its continued cooperation to the Department of Health, Education, and Welfare on other health programs.

A group of A.M.A. officials headed by Dr. Askey told the news H.E.W. secretary, former Gov. Abraham Ribicoff of Connecticut, at a pre-inaugural conference, that the Association "pledges its continued cooperation to H.E.W. to work for the best medical care for the nation." The A.M.A. "has always had a deep sense of responsibility for the health needs of the people," Dr. Askey said.

The A.M.A. officials also advised Ribicoff that they would help implement the Kerr-Mills law in any way possible.

A MEMORIUM TO GEORGE L. BROADRICK

THE GREAT MAKER HAS seen fit to call George L. Broadrick to rest on December 6, 1960 after more than a half century of devoted service to the people of Whitfield County and North Georgia in the treatment of their physical and mental ills, regardless of economic status. His devotion to his chosen profession was unswerving and unexcelled, no matter what the hour or inconvenience to himself. He was held in the highest esteem by his fellow practitioners locally and statewide, having served as president of the Whitfield Coun-

ty Medical Society and Seventh District Society, as well as other positions in these societies. His guiding influence and counsel will be sorely missed by both the medical profession and lay public of this County.

The members of Whitfield County Medical Society have a great feeling of loss on the death of Doctor George L. Broadrick.

This memorium was prepared by a committee of members of the Whitfield County Medical Society.

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SERUM TRANSAMINASE IN DISEASES OF MUSCLE

REPORT OF A CASE OF POLYMYOSITIS

The serum level of transaminase is more likely to be elevated in primary diseases of muscle than in cases of atrophy secondary to diseases of the nervous system.

John A. Ward, M.D. and Emmalen M. Smith, *Atlanta*

SERUM TRANSAMINASE DETERMINATIONS have proved useful adjuncts in medical diagnosis, particularly in cardiac and hepatic diseases.^{1,2,3} Interpretation of the results of the transaminase tests must be done with a certain degree of caution since such relatively non-specific causes such as surgery⁴ and physical trauma⁵ have been reported to elevate the serum transaminase.

Since one of the major uses of the serum oxaloacetic transaminase is the evaluation of damage to myocardial muscle, it seemed interesting to study transaminase in relation to diseases of striated muscle. The following case of polymyositis is an example of skeletal muscle disease with rather marked elevation of the serum transaminase, presumably for over a year.

Case Report

R. C., a 33-year-old white male electrician, was admitted to a private hospital from Nov. 29, 1957 to Dec. 10, 1957 with a chief complaint of dysphagia and a 25-pound weight loss over a three-month period. His discharge diagnosis was dermatomyositis. Following discharge, he had been taking prednisone 15 to 45 mg. daily. He had noted some improvement in his dysphagia while taking steroids but continued to have stiffness and soreness of all muscle groups.

On admission to the Atlanta V. A. Hospital Jan.

6, 1958 to Feb. 2, 1958, he noted marked restriction of movement of shoulders and hips. Physical examination revealed an emaciated, chronically ill, white male with normal vital signs weighing 120 lbs. The extremities showed evidence of general loss of muscle most marked around the shoulder girdle. Motion of the arms was limited at the shoulders and flexion of the hips was restricted to a relatively small range of motion. No twitchings or fibrillations were present.

X-rays: Chest of Jan. 6, 1958 was reported as negative. GI series of Jan. 9, 1958 reported a delay in regurgitation into the pharynx on swallowing. On Jan. 9, 1958 hands were reported as normal. Hips and feet of Jan. 13, 1958 were reported as negative. Shoulders showed some osteoporosis around the joint.

Electrocardiogram was essentially normal. On Jan. 7, 1958 routine blood count showed WBC of 17,650 with 83 S, 13 L, and four M; hemoglobin 16.6 gms. per 100 ml.; sedimentation rate 14 mm/hr; hematocrit 48 per cent. Serology was negative. Routine urinalysis was within normal limits. On Jan. 7, 1958 blood urea nitrogen was 8.2 mg/100 ml; CO₂ 24.6 meq/l; Na 141.3 meq/l., and Cl 99.7 meq/l. On Jan. 10, 1958 routine blood count showed WBC of 15,250 with 79 S, 16 L, four M, and one E; hemoglobin 17.2 gm/100 ml; sedimentation rate 15 mm/hr.; hematocrit 54

SERUM TRANSAMINASE / Ward

per cent. Serum potassiums were Jan. 10, 1958, 7.4 meq/l.; Jan. 14, 1958, 4.6 meq/l.; Jan. 23, 1958, 4.2 meq/l.; Jan. 29, 1958, 6.3 meq/l., and Feb. 12, 1958, 5.1 meq/l. Seventeen ketosteroids were 7.42 mg./24 hours.

Review of previous biopsies were reported as non-specific myositis of the deltoid muscle and skin changes suggestive of scleroderma, but not diagnostic.

The patient was placed on 30 mg. prednisone daily and passive physiotherapy. Some subjective but no objective improvement was noted. After discharge the patient was treated by another institution but seen here on follow-up visits.

From Table I the creatine excretion was markedly elevated while the creatinine is below normal. Creatinine excretion is said to be decreased in dermatomyositis and diseases of muscular degeneration.⁶ Elevated serum transaminase levels have been reported in dermatomyositis.^{7,8} Serum transaminase may remain elevated for months⁹ in diseases of muscle, as in the present case, and may represent continued activity of the disease process.

TABLE I

	Serum glutamic oxalacetic transaminase units	Serum glutamic pyruvic transaminase units	24-hour urine creatinine M.G./24 hrs.	24-hour urine creatinine M.G./24 hrs.
Normal	1-40	1-45	0-200	1000-1800
Date				
1-10-58			907	603.5
2-25-58	160	120		
6-24-58	170	> 150		
4-22-59	220	> 150		
6-4-59	164	> 150		
6-9-59			2556	380

While myocardial changes have been reported in dermatomyositis¹⁰ it does not seem likely that there was significant cardiac involvement in the present case, in the absence of cardiac signs and symptoms, and with a normal electrocardiogram.

Other diseases characterized by muscle injury or atrophy were studied and the data recorded in Table II.

The results of the table agree with the findings of previous authors^{9,11,12} who did not find elevation of serum transaminase in muscular atrophy secondary to disorders of the central nervous system or peripheral nerves.

Summary

- 1. A case of polymyositis with persistently high serum transaminase presumably over a 16-month period had been reported.
- 2. Studies on other diseases characterized by muscle atrophy concur with the reports of others

TABLE II
SERUM TRANSAMINASE IN CONDITIONS AFFECTING
SKELETAL MUSCLE

	Patient	SGOT	SGPT
Normal Range		1-40	1-45
NERVOUS SYSTEM			
Muscular atrophy due to intra-cranial disease (cerebrovascular and metastatic disease)	J.H.	10	9
	H.R.	19	10
Muscular atrophy following poliomyelitis	H.G.	18	12
	L.S.	22	12
Amyotropic lateral sclerosis	R.W.	20	14
	T.E.	15	12
	L.G.	18	10
	L.J.	38	19
Muscular atrophy associated with neuropathy of unknown cause	K.J.	18	12
	M.L.	15	14
Muscular atrophy of unknown cause without neuropathy (questionable disuse atrophy)	J.B.	24	22
	A.H.	21	22
MUSCULAR SYSTEM			
Trichinosis (Post Acute Stage)	R.W.	23	13
Myotonia dystrophica	T.M.	49	38
Dermatomyositis	R.C.	160	120
VASCULAR SYSTEM			
Acute peripheral arterial embolus	W.B.	167	40

that the serum transaminase is more likely to be elevated in primary diseases of muscle than atrophy secondary to diseases of the nervous system.

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THE TREATMENT OF HYDROCEPHALUS

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Several simple and relatively satisfactory techniques have been evolved in the last few years.

HYDROCEPHALUS IS NOT A disease with a single etiology, but a symptom complex and may be due to more than one cause. The term is a descriptive one and means literally increased fluid within the brain and should always imply increased intracranial pressure. It is convenient to think of hydrocephalus as being divided into two main types: primary which is congenital and the secondary type due to obstruction of the circulation of flow of the cerebrospinal fluid due to tumor or infectious processes or due to an over production of fluid.

There is statistical evidence that congenital hydrocephalus is a genetically transmitted disorder fostered by disturbances in maternal metabolism during the first trimester. The overall incidence of hydrocephalus is two to three per 1000 births occurring more often in male than in female babies. The disorder is a recessive sex-linked disorder. The genetic factor is usually strong but the environmental factors of maternal nourishment and diet in the first trimester favors its occurrence. The maternal dietary factor is supported by the increased occurrence in the lower social classes having poor nourishment and hydrocephalus can be produced experimentally by altering the maternal diet. Hydrocephalus is more commonly seen in those families with a high incidence of stillbirths or abortions and with interfamily marriage. The question is always asked of the physician by the family after the birth of a hydrocephalic child,

"What are the chances of our having another hydrocephalic baby?" It should be stated to the family that the risk is considerably greater than in the usual population and that their chances are probably one in 14 that they may have a second. The incidence is greatest in the first born and then becomes greater with high *maternal age* of 35 years plus.

There has been no good statistical study of secondary hydrocephalus. These cases more often lend themselves to satisfactory definitive therapy.

Understanding of Etiological Types

Any discussion of treatment demands an understanding of the etiological types in order to consider as definite and direct a form of therapy as is feasible for the relief of that particular type of hydrocephalus. It is important to discuss thoroughly with the family of a hydrocephalic child the necessity of evaluating what is to be expected of the treatment and whether or not an acceptable life for the individual will result with treatment. Many times a successful shunting procedure will sustain a hopeless defective child who is wholly unable to mature into a functioning individual. Parents should be told of the necessary special studies to be carried out to determine the precise type of hydrocephalus and that it is necessary to evaluate the rate of growth of the head as related to the other body parts. Only after this has been carefully considered can an accurate statement with recommendation for treatment be made to the family. A variety of bypass shunt procedures are now being performed on hydrocephalic babies with enlarged heads. Many patients who have an enlarged head may not have an active hydrocephalus and there is need for a period of observation and a clinical appraisal of the mental and phys-

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ical capabilities of this child. The reason for the increased number of hurried early shunts is probably due to the fact that there are now more simple techniques that offer more hope of success.

If after the examination and tests are carried out it is felt that the child has irreversible damage and loss of brain tissue with blindness or irreparable motor loss, the family is so advised. They should be told that it will be impossible for their child to develop into a mature functioning individual and the child should not receive surgical treatment but instead receive good supportive care and be kept from suffering.

If after the definitive tests have been carried out, still there is uncertainty on the part of the physician, it is well and necessary to explain to the family that there is a possibility that the hydrocephalus has spontaneously arrested and that there will need to be repeated check-ups and measurements of the head and chest and a careful clinical follow-up and evaluation to determine whether or not the hydrocephalus is accompanied by progressively increased intracranial pressure. The family should be made to feel that this approach is not procrastination, but a planned course of management and that measurements and further studies are needed at regular intervals until either a decision can be made that the

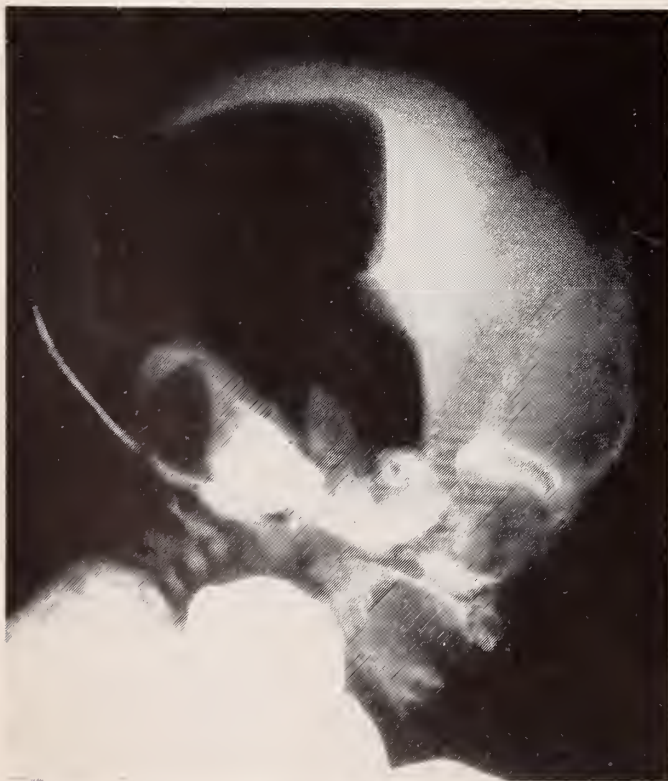


Figure 1: Lateral view ventriculogram in a case of obstruction at the foramina of Magendie and Luschka. Note the small loculation of air immediately below the posterior rim of the occiput extending to the posterior arch of the first cervical vertebrae. This projection of the cyst within the cervical canal along with the enlarged posterior fossa cyst is pathognomonic of the Dandy-Walker deformity and resultant hydrocephalus.



Figure 2: Ventricular bubble study in a case of obstructive hydrocephalus secondary to the Arnold-Chiari malformation. Note the enlarged third ventricle. There is no air in the aqueduct of Sylvius, the fourth ventricle, cisterna magna or upper cervical spinal canal. Note the absence of air in the subarachnoid pathways.

child has a progressive hydrocephalus or that the condition has been arrested and does not need treatment. Careful measurements of the head and comparing this with the known growth charts as related to the other body parts will usually confirm the diagnosis of progressive hydrocephalus. In a certain number of cases, however, the hydrocephalus may progress without too great an enlargement of the head and mostly at the expense of the brain tissue. This can only be determined by the repeated pneumoencephalographic or ventriculographic pictures. It is not uncommon to see the brain tissue reduce from four to three centimeters while under observation and the child may eat and appear quite well and have only a minor increase in the circumference of the head not unduly inconsistent with the normal growth charts. However, there is always a steady and consistent increase in head size.

In the congenital hydrocephalic babies there will be a certain number that have a surgically resectable arachnoidal cyst, a failure of opening of the foramen of Luschka or Magendie (Figure 1) or a septum pellucidum cyst with obstruction. Satisfying results are obtained by opening the congenital arachnoidal cyst, opening the septum pellucidum cyst or making openings of the closed foramen of Magendie and Luschka and allowing the normal route of drainage. Such cases should not be treated by an artificial shunt and valve mechanism as these man-

made apparatuses are subject to all of the frailties and difficulties that come with any prosthetic device.

The hydrocephalus that comes with the Arnold Chiari malformation (Figure 2) is usually the result of failure of the spinal fluid to have room to flow from the fourth ventricle and cisterna magna because of compression of the structures at the foramen magnum with a small posterior fossa. A definitive decompression of the posterior fossa may in certain cases relieve the obstruction if the procedure is adequate. However, the subarachnoid pathways may not be open and functioning; then the condition must be treated the same as the other hydrocephalics present at birth due to aqueductal forking, namely the bypass shunt. (Figure 3).

A form of congenital hydrocephalus that lends itself to definitive surgical procedure is that of an atresia or absence of the foramen of Luschka and Magendie. This may occasionally be the result of a congenital absence or the blockage by blood in the fourth ventricle or in the subarachnoid space. An air study (Figure 1) in this particular malady is quite characteristic and an artificial shunt is not indicated in this hydrocephalus that lends itself to direct surgical attack.

Once it has been established that there is a congenital hydrocephalus not amenable to definitive therapy, our best method of treatment is that of shunting the spinal fluid around the point of obstruction into a receptor organ by artificial means with tubing and valves. The best surgical results will come in those cases that are early recognized and given early treatment. By far the greatest number of the congenital hydrocephalic cases are those due to failure of development or a forking of the aqueduct of Sylvius (Figure 3).

Evolution of Treatment

The evolution of the treatment of congenital hydrocephalus is one of a long account of multiple therapeutic procedures. This is evidence that a completely satisfactory method for drainage has not yet been devised. Several simple and relatively satisfactory technics have been evolved in the last few years. The body at each turn has defied a completely satisfactory artificial circulation. Each method, however, has pointed toward the proper physiological principles necessary for a satisfactory shunt procedure. Of the shunting methods there are four that give hope of protracted relief: (1) the ventriculo-cervical shunt; (2) the ventriculo-ureterostomy or lumbar subarachnoid ureterostomy; (3) ventriculo-caval or ventriculoauricular shunt, and (4) the ventriculobiliary or subarachnoid biliary shunt.

The first of these (Figure 4) is a modified ventriculo-cisternal shunt introduced by Torkildsen¹ in 1939. The modification is one of not opening the

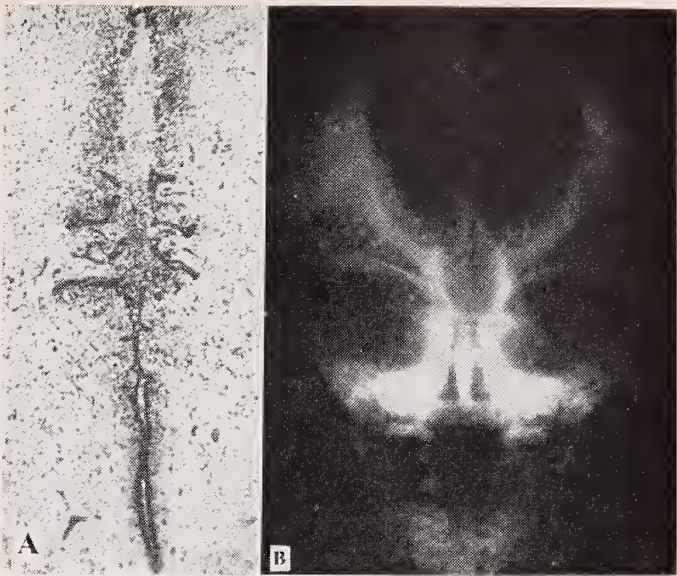


Figure 3: (A) Histological section taken through the midbrain showing forking and failure of formation of the aqueduct of Sylvius. (B) Ventriculogram showing internal hydrocephalus due to failure of development of the aqueduct of Sylvius.

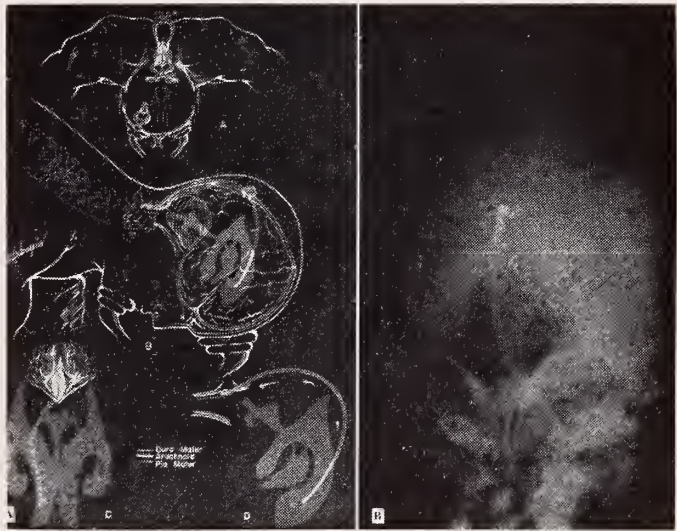


Figure 4: (A) Artist's conception of modified Torkildsen procedure, ventriculocervical anastomosis, as shown from different angles. (B) Skull x-rays showing portion of rubber tube in a ventriculocervical shunt.

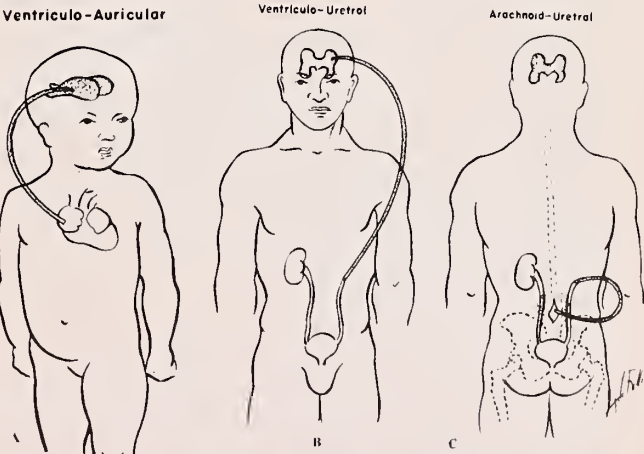


Figure 5: (A) Diagrammatic sketch showing ventriculocaval or ventriculo-auricle shunt. (B) Ventriculouretral shunt. (C) Spinal arachnoid-uretral shunt.

posterior fossa or cisterna magna but inserting the tube into the cervical subarachnoid space at C1-C2. The second method introduced in 1908 by Heile² and subsequently popularized by Matson³ is the ventriculo-ureterostomy (Figure 5). The third procedure recently introduced has become the most popular procedure within the last ten years (Figure 5). The fourth procedure (Figure 6); namely, drainage of the spinal fluid into a gall bladder was introduced at The Medical College of Georgia.⁴

Artificial Shunt Mechanism

For an artificial shunt mechanism to work satisfactorily and to persist, the following criteria must be satisfied:

1. The receptor organ must be relatively sterile.
2. Blockage of the shunt mechanism by fibrin or other material must be obviated.
3. Opportunity must be provided for the re-sorption of water and electrolytes contained in the shunted cerebrospinal fluid.
4. Physiological intracranial pressure should be maintained.
5. The shunt mechanism must not interfere with other physiological processes or constitute a physical detriment to the patient.

The procedure of shunting spinal fluid into the

ureter (Figure 5b) requires sacrifice of a kidney and a disabling electrolyte imbalance may result due to the continued loss of cerebrospinal fluid particularly chlorides and potassium. There is a hydrostatic imbalance of the cerebrospinal fluid. There is the possibility of a resultant retrograde infection with meningitis. There is frequently a necessity to adjust the distal end of the tube which may become obstructed due to fibrosis.

Problems with Shunting

The problems associated with the shunting of the cerebrospinal fluid into the blood stream by way of the superior vena cava or the heart (Figure 5a) are those associated with placing a foreign body in the blood stream and into a vital organ. A significant incidence of septicemia and endocarditis results with this procedure. The inherent difficulties of a mechanical valve are present and there is a likelihood of reflux or obstruction occurring at the distal end of the tube requiring multiple operations and adjustment of the tube and valve. The limitation of being able to shunt cerebrospinal fluid only from the ventricle is imposed on those shunts going into the vena cava or auricle.

The gall bladder probably constitutes the most

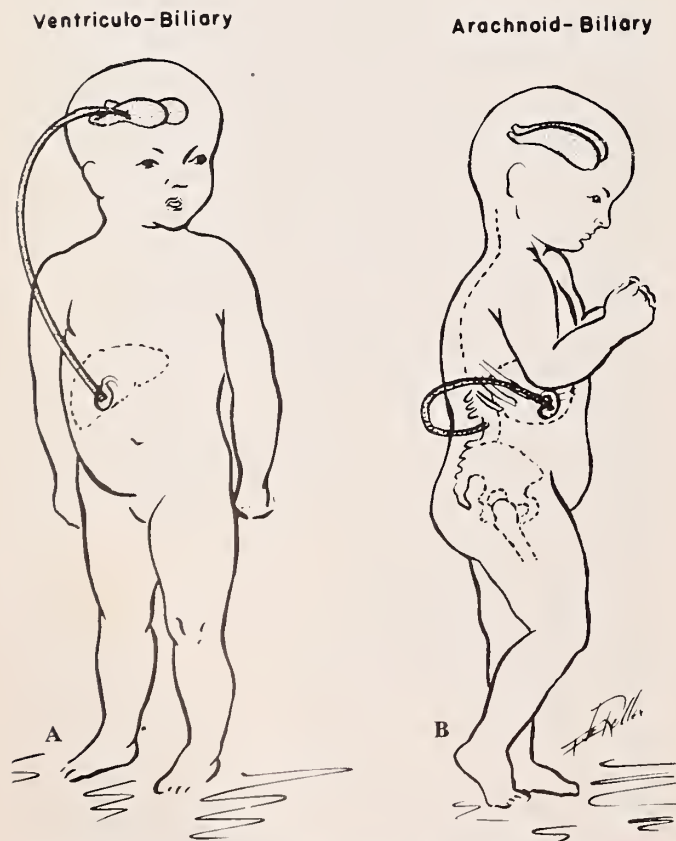


Figure 6: (A) Ventriculo-biliary shunt. (B) Arachnoid-biliary shunt.



Figure 7: Subarachnoid biliary shunt. Operative exposure with plastic capsule anastomosed to the fundus of gall bladder.

suitable receptor organ.⁴ The advantage of this procedure is that the biliary tract is a relatively sterile system in the absence of biliary obstruction. There is ample opportunity provided for a resorption of electrolytes and fluid from the gall bladder mucosa and upper gastrointestinal tract. Hydrostatic pressure within the biliary system is comparable to the intracranial pressures. It is not necessary to sacrifice the gall bladder (Figure 7). It is impossible for fibrous reaction to form in the distal end of the tube due to the extreme lytic action of bile, thus preventing the plugging and obstruction of the artificial drainage tube.

Best Results with Shunting

Regardless of the procedure performed, the best surgical results with shunting procedures will be in those cases in which the increased intracranial pressure is attacked early and with a single surgical procedure. The chances of a successful result diminishes with the multiplicity of surgical procedures. The greatest and gravest single complication is that of infection along the course of the artificial tube. The likelihood of an infection is compounded by the number of operative procedures. Once infection has become established in the central nervous system a good result can rarely be achieved. Likewise hemorrhage into the central nervous system with the diagnostic or shunting procedures will prevent a satisfactory result. The drainage tubes are buried in the subcutaneous tissues or deep to the muscle layers in its course. The more superficially a tube is placed the greater the incidence of infection along its course. By keeping the silicone shunt tubing of very small caliber and burying this deep to the muscle, where foreign body and infection can be best handled, our failures and complications have been reduced.

Stenosis or Partial Obstruction

One type of hydrocephalus that gives a most satisfactory result is that which we are seeing with increasing frequency. That is the youth or child who has a stenosis or partial obstruction in the aqueduct of Sylvius and is functioning on a borderline circulation, but suddenly completely occludes with a systemic infection. This condition is usually seen in older children up to 15 or 20 years of age. These cases can be treated by a shunt bypass of the cerebrospinal fluid from the lateral ventricle into the upper cervical subarachnoid space (Figure 4). These children usually have their skulls well fixed at the suture line and can show little, if any, increasing size in the head circumference. They show limited neurological signs except for those of increasing

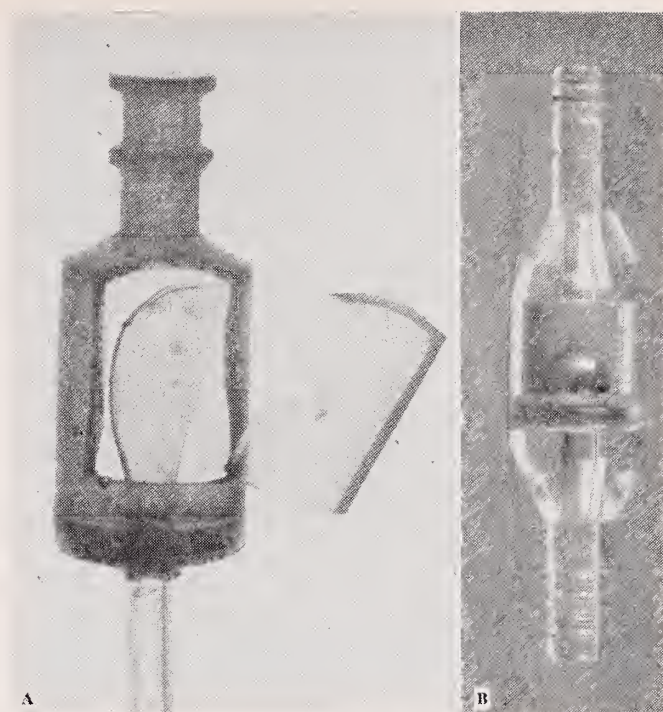


Figure 8: Prototype valve used in the shunting of cerebrospinal fluid into the ventricles of the gall bladder. (A) Original lucite capsule with polyethylene flutter type valve mechanism. A window has been cut to show the leaflets of the valve. (B) Magnetic valve made of lucite. This is magnetized with a ferrus ball. This is the prototype of the valve used in the more recent ventriculo-biliary shunts. The magnetic action of the valve is sufficiently great that the ball will unseat at 100 mm. of water pressure. The moment this pressure is no longer present the ball is immediately drawn to its seated position which prevents reflux of bile.

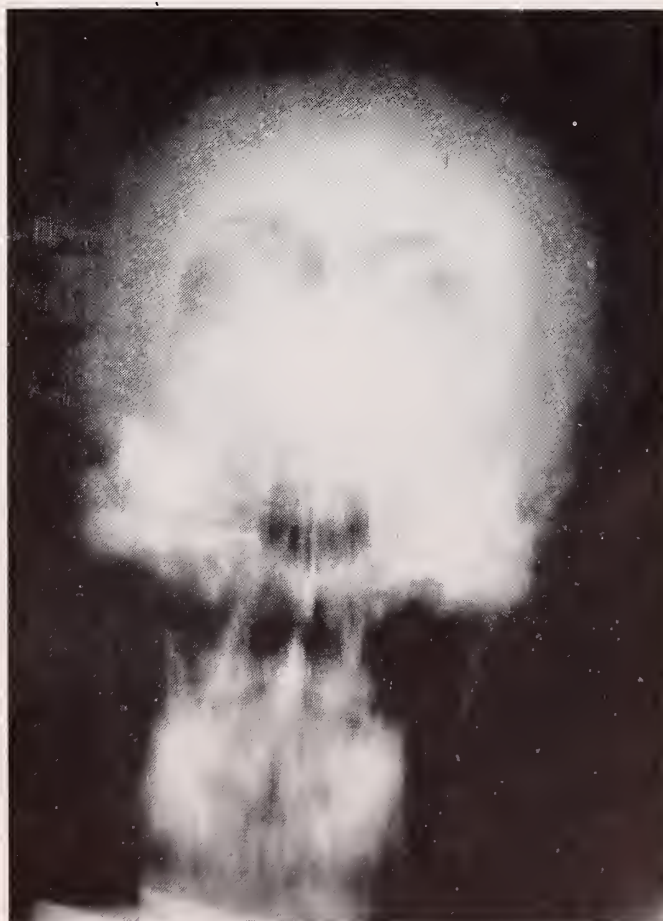


Figure 9: Laminogram air study of patient with bilateral choroid plexus papiloma and hydrocephalus. Note the outlining of the tumor mass in each lateral ventricle.

HYDROCEPHALUS / Smith

intracranial pressure with diplopia, loss of vision and papilledema. A common history is that of a recent infection followed by the signs of increasing intracranial pressure. So many congenital hydrocephalics have never had a normal functioning subarachnoid pathway but in this group of patients the circulation of cerebrospinal fluid has been satisfactory prior to the sudden occlusion of a borderline functioning aqueduct of Sylvius. Accordingly the treatment is most satisfactory and requires only a simple shunt bypass from the lateral ventricle to the upper cervical subarachnoid pathways (Figure 4). It is felt this procedure is better than the classical Torkildsen procedure¹ in which the bypass tube is brought from the lateral ventricle into the posterior fossa and cisterna magna. It is wise not to open the posterior fossa unless there is a strong suspicion of a posterior fossa tumor. The most common post-infections hydrocephalus that we see is communicating hydrocephalus with obstruction of the subarachnoid pathways at the base of the skull and around the brain stem at the inunstramentum.

As regards the secondary types of hydrocephalus, these are most often due to a tumor of the posterior third or fourth ventricle. The diagnosis of the tumor in this area is often very difficult and the differential diagnosis between congenital hydrocephalus or an atresia of the aqueduct of Sylvius requires careful

dye and air contrast studies both from the ventricular and lumbar spinal routes. If the tumor is not located properly for surgical removal, then a posterior fossa decompression and a ventriculo-cervical subarachnoid shunt is indicated followed by x-ray therapy if indicated.

One of the more interesting but rare secondary hydrocephalic conditions is that associated with tumors of the choroid plexus. A papilloma of the choroid plexus will produce hydrocephalus not necessarily on the basis of an obstructive lesion but on the basis of hypersecretion of cerebrospinal fluid. They give a characteristic ventriculographic picture (Figure 9) usually with unilateral dilatation of one lateral ventricle and have all of the clinical signs of increasing head size and intracranial hypertension. These tumors respond nicely to surgical removal with complete relief of the hydrocephalus.

Medical College of Georgia

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STATE TB HOSPITAL ACCREDITED FOR THREE YEARS

BATTEY STATE HOSPITAL, which was recently under an evaluation study, has been accredited for three years by the Joint Commission on Accreditation of Hospitals, Chicago, Illinois.

Dr. Raymond F. Corpe, Superintendent of the tuberculosis hospital, received a letter recently from Dr. Kenneth B. Babcock, Director of the Commission, commending the hospital for "maintaining standards deserving of accreditation" and for "constant effort to improve the quality of patient care."

The survey of the hospital was conducted January 10-11 by Dr. Karl F. Weir, a field representative of the Commission. In his recommendations and comments, Dr. Weir stated that "The medical staff, administration

and key personnel are commended for the high quality of patient care being provided here as observed by the field representative of the Joint Commission on Accreditation of Hospitals. The medical records were of exceptionally good quality, for this the medical staff is commended. This good effort should be constantly continued."

Recommendations were also made for certain minor improvements in records procedures.

The Joint Commission is composed of representatives from the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the American Medical Association.

PHLEGMASIA CERULEA DOLENS OCCURRING WITH COUMADIN® ANTICOAGULATION

William H. Chambless, M.D. and William D. Logan, Jr., M.D., *Atlanta*

Review of pathogenesis and management.

PHLEGMASIA CERULEA DOLENS is a term used to describe one of the more infrequent manifestations of thrombophlebitis. This syndrome has been described as a massive venous occlusion, both superficial and deep, associated with fulminating, non-suppurative thrombophlebitis.^{7,9,18,14,12} Some of the original reports in the American literature concerning this entity were done by Haimovici, Oschner, and DeBakey in 1949 and 1950.^{7,14} Other reports question this as a separate entity because of its ill-understood etiology and pathogenesis.^{6,9}

This is a report of a case showing some unusual features and a review of the complexities in the diagnosis and management of peripheral venous occlusive phenomenon.

Case History

A twenty-eight-year-old, G₇P₇A₀, was admitted in December, 1959, with a diagnosis of deep thrombophlebitis in the right lower extremity. She was treated with bed rest, Coumadin,®* and antibiotics, and symptoms began subsiding. Three days after admission, she developed sudden throbbing pain, edema, and cyanotic discoloration of the right foot. The prothrombin time was approximately 20 per cent. Past history revealed that the patient had been treated several times between 1954 and the present as an in-patient and out-patient with a diagnosis of superficial and deep thrombophlebitis. Most of these episodes occurred post-partum. They were mild and left no evidence of post-phlebitic sequelae. In 1955 a diagnosis of squamous cell carcinoma of the cervix

uteri, Stage I, was made, and the patient treated with radiation. Follow-up examination failed to reveal any recurrence of neoplasm.

Physical examination revealed a cachectic and anemic female with violaceous discoloration of the right foot, more marked in the distal half, suggesting early gangrene. There was edema of the right foot and calf with distended and tender superficial veins. The dorsalis pedis pulse was palpable. Due to the marked discoloration and coolness of the distal foot and toes, the possibility of arterial disease was considered, but a final impression of phlegmasia cerulea dolens was made. Pelvic examination failed to reveal any evidence of recurrent carcinoma.

A regimen of I. V. heparin, 50 mgm. q. 4 h., elevation of the leg, and analgesics were instituted.

She had almost immediate relief of pain with elevation and continued with significant improvement in the congestion and color of the foot during the following two days. After ten days, the foot and toes were normal color with no edema or pain, and the patient was discharged on Coumadin® anticoagulation. No sequelae resulted.

Except for anorexia, she was asymptomatic until Feb. 10, 1960, at which time she developed superficial thrombophlebitis of the left leg. She had been maintained on Coumadin® therapy since the previous admission. This was followed by deep thrombophlebitis on Feb. 15, 1960, and the patient was admitted to the hospital. The prothrombin time on this admission was five per cent. Pelvic examination again failed to reveal carcinoma. Chest x-ray was negative. Hemoglobin was nine gm. and the patient was given whole blood. She was treated with Couma-

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*Coumadin is the trade name for warfarin sodium (Endo).

PHLEGMASIA CERULEA DOLENS / Chambless

din,[®] bed rest, and Butazolidin.^{®*} Following chest pain which occurred several days after admission, x-rays revealed minimal pleural effusion with a diagnosis of questionable pulmonary infarction on the left.

On Feb. 18, 1960 the patient had a sudden onset of pain in the left leg. The leg developed a violaceous color with blotches involving the entire extremity, but more pronounced distally. The entire leg became edematous and markedly tender. The superficial veins were distended. No pulses were felt in the entire extremity, but there was capillary filling to the ankle. The distal extremity was cool. There was decreased motor and sensory findings of the distal leg and foot (Figure 1).

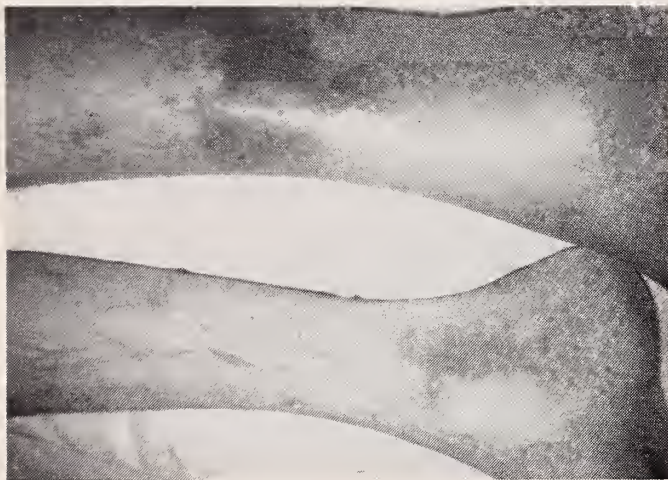


Figure 1 (A).

Again the diagnosis of phlegmasia cerulea dolens was made, and the patient received I.V. heparin, elevation, and analgesics. Pain was very severe and not controlled with narcotics. K₁ oxide was given I.V., and a lumbar sympathetic block was done. This gave marked relief of pain, improving the temperature of the foot and lessening the discoloration. No pulses returned. Heparin was restarted. After six hours, pain recurred and a continuous epidural block was instituted using 0.1 per cent Novocaine[®] through a polyethylene tube in the epidural space at the level of L-3. This was very successful in relieving pain and was continued for three days.

She had gradual improvement of the leg, which after ten days showed no edema or discoloration, and all pulses were palpable. There was dry gangrene of the third toe (Figure 2).

At this time an enlarged supraclavicular node was noted, and a biopsy of this and the cervix showed squamous cell carcinoma. Repeat chest x-ray revealed clear lung fields. General consultations did



Figure 1 (B).

not feel the treatment of carcinoma was indicated in view of metastatic disease.

She was discharged on Coumadin[®] anticoagulation. On March 3, 1960 she developed superficial thrombophlebitis of the left arm. Prothrombin time was below zero per cent at that time.

Another episode of acute pain, discoloration, and edema developed in the left lower leg on March 28, 1960. She was admitted and treated with heparin, elevation, and analgesics plus Butazolidin.[®] She improved to the point of out-patient care in one week. There remains mild edema of the distal leg and dry gangrene of the second and third toes (Figure 3).

Comment

This case presents episodes of repeated migratory phlebitis over a six-year period with a diagnosis of carcinoma of the cervix being made four years following initial phlebitis. The relationship of venous disease to pelvic carcinoma in this patient is speculative. Many reports in the literature closely correlate these conditions,^{9,16,18,7} but Anylan, et al., doubt any significant relationship.¹ However, the massive venous occlusive phenomenon occurred in this case in conjunction with recurrent and metastatic carcinoma.

This is an unusual case of phlegmasia cerulea



Figure 2.

dolens, occurring bilaterally and twice in one extremity. Phlegmasia cerulea dolens occurred while the patient was in the considered therapeutic range of Coumadin® therapy. Heparin appeared to give a better therapeutic effect, which agrees with other reports.^{1,2,4,9,11,14,16,24}

There are numerous conflicting publications concerning the efficacy of sympathetic blocks in venous occlusive disease.^{10,8,6,16,18,15} The role of arterial and venous spasm occurring with thrombophlebitis is a subject of much discussion. Oschner believes that arterial spasm is due to a compensatory reflex sympathetic activity.⁷ Haimovici, however, feels that the arterial spasm occurs secondary to periphlebitis.¹⁴ Most authors feel that vasospasm is the primary cause of pain in this condition.^{10,6,21,11,7,18,9} The role of venous spasm has not been adequately elaborated.

This patient had remarkable relief of pain with simple elevation during the first episode of phlegmasia cerulea dolens. However, lumbar sympathetic blocks were necessary, in addition to elevation, to relieve the pain in the second episode. A continuous sympathetic block was maintained with an epidural catheter, which avoided the danger of repeated needle puncture when the patient was on anticoagulant therapy.

Mahorner, Edwards, and others recommend femoral thrombectomy to initiate venous flow,^{11,16} while others do not advocate this because of possible risks involved. In early reports on this subject, some authors advocated ligation of the vena cava to avert ascending thromboses and thromboembolism.^{7,12} Anti-inflammatory agents such as Butazolidin® and steroids have been used by some, but condemned by others.^{22,24,25} Veal reports that exercise of the involved extremity is beneficial, if started in the early phase of the process, but may be dangerous if initiated after two days.²⁶ Edwards states that any exercise is dangerous.¹¹

Tissue necrosis and gangrene are frequent sequelae of phlegmasia cerulea dolens.^{9,13,14,18,19} Dry gangrene of the second and third toes on the left occurred in this case after two major episodes of phlegmasia cerulea dolens. Most investigators feel that tissue necrosis is due to inadequate capillary circulation secondary to venous occlusion, and not due to arterial spasm.^{7,10,19,20}

Discussion

The onset of venous occlusive disease is usually insidious, becoming obvious after several hours or even days. Phlegmasia cerulea dolens, however, is characterized by a sudden onset of massive venous occlusion. This results in vascular congestion of the extremity involved with tissue anoxia and frequent gangrene. Arterial spasm occurs secondarily with

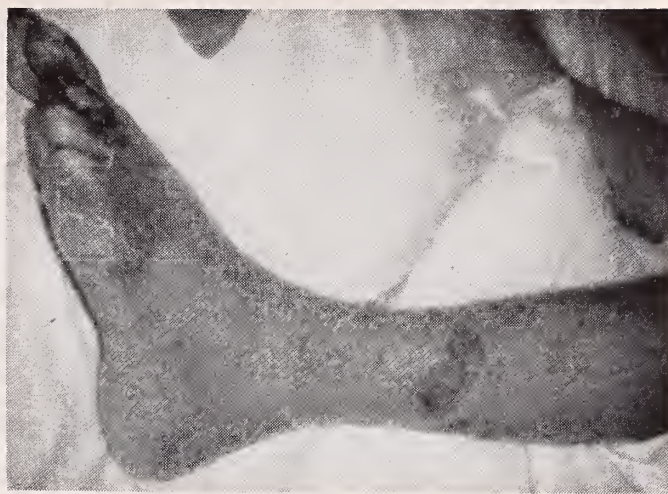


Figure 3.

varying degrees. Venous spasm probably occurs also, but this is doubted by some investigators.¹³

The same etiological factors involved in deep thrombophlebitis occur with phlegmasia cerulea dolens, i.e., postoperative status, debilitated states, anemia, carcinoma, partial mechanical obstruction of vessels, and non-specific intravascular thrombotic tendencies. The reason for sudden massive venous occlusion has not been explained.

The differential diagnosis of arterial occlusive disease is foremost in some of these cases. Vascular problems exist with small artery disease, mixed or combined arterial and venous disease, and pure arterial or venous disease. The main differential points indicating phlegmasia cerulea dolens are: (1) sudden onset; (2) rapidly progressing edema; (3) violaceous discoloration; (4) variability of pulses; (5) temperature changes inconsistent with pulses; (6) distended and tender superficial veins; (7) evidence of prompt capillary filling, and (8) excruciating pain.

Arteriography has been reported as helpful in differentiating arterial disease.¹⁴

Results

In approximately 50 per cent of cases with phlegmasia cerulea dolens, gangrene occurs, but is usually superficial.^{7,12,14} There have been cases reported of massive gangrene requiring amputation. Oschner and DeBailey report ten per cent of their cases had pulmonary emboli.⁷ Due to the frequent concomitant morbid disease which results in death, the prognosis of phlegmasia cerulea dolens is difficult to determine.⁷

Summary

1. An unusual case of phlegmasia cerulea dolens is presented.
2. The differential aspects of diagnosis and management are discussed.

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PHLEGMASIA CERULEA DOLENS / Chambless

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Whitfield County Medical Society, Woman's Auxiliary	Dalton

1961 CALENDAR OF MEETINGS

State

Apr. 9—Georgia Society of Clinical Hypnosis, Cafeteria, Talmadge Memorial Hospital, Augusta.

May 7-10—Annual Session, Medical Association of Georgia, Atlanta Biltmore Hotel, Atlanta.

June 7-9—Georgia Board of Medical Examiners, Examination and Endorsement, Atlanta and Augusta.

June 11-14—Georgia Pharmaceutical Association, Biltmore Hotel, Atlanta.

Sept. 8-9—Thirteenth Annual Meeting, Georgia Heart Association, Jekyll Island.

Regional

Apr. 6-8—14th Annual Meeting, West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Virginia.

Apr. 9-12—Tennessee State Medical Association, Read House Hotel, Chattanooga, Tennessee.

Apr. 22-25—Texas Medical Association, Galvez and Buccaneer Hotels, Galveston, Texas.

Sept. 19-21—Kentucky State Medical Association, Brown Hotel, Louisville, Kentucky.

Sept. 25-26—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tennessee.

Nov. 6-9—Southern Medical Association, Municipal Auditorium, Dallas, Texas.

Dec. 5-7—Southern Surgical Association, Hot Springs, Virginia.

National

Apr. 3-8—The Gill Memorial Eye, Ear and Throat Hospital, 34th Annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties, Gill Memorial Eye, Ear and Throat Hospital, Roanoke, Virginia.

Apr. 3-15—Eleventh Medical Conference, Bahamas Conferences, Nassau, Bahamas.

Apr. 6-8—Fourteenth Annual Meeting, West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Virginia.

Apr. 10-12—American Academy of Pediatrics, Sheraton-Park Hotel, Washington, D. C.

Apr. 11-14—American College of Physicians, Postgraduate Course, The Lankenau Hospital, Philadelphia, Pennsylvania.

Apr. 17-20—American Academy of General Practice, Miami Beach, Florida.

Apr. 20-28—American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour, Florida.

Apr. 30-May 6—Conference on Internal Medicine, Bahamas Conferences, Nassau, Bahamas.

May 2-3—American Pediatric Society, Hotel Traymore, Atlantic City, New Jersey.

May 5-7—American Society of Internal Medicine, Eden Roc Hotel, Miami Beach, Florida.

May 8-12—American College of Physicians, Americana Hotel, Miami Beach, Florida.

May 8-12—American Psychiatric Association, Morrison Hotel, Chicago, Illinois.

May 15-19—Postgraduate Course in Gastroenterology, University of Pennsylvania Graduate School of Medicine, Philadelphia, Pennsylvania.

May 16-20—American College of Cardiology, Inc., Biltmore Hotel, New York, New York.

May 22-24—American Thoracic Society, Netherland-Hilton, Cincinnati, Ohio.

May 22-25—American Urological Association, Inc. Biltmore Hotel, Los Angeles, California.

May 22-25—National Tuberculosis Association, Netherland-Hilton, Cincinnati, Ohio.

May 29-31—American Gynecological Society, The Broadmoor, Colorado Springs, Colorado.

June 19-23—Postgraduate Course in Current Aspects of Internal Medicine, State University of Iowa College of Medicine, Iowa City, Iowa.

June 22-26—American College of Chest Physicians, Hotel Commodore, New York, New York.

June 24-25—American Diabetes Association, Commodore Hotel, New York, New York.

June 26-30—American Medical Association, Annual Meeting, New York, New York.

Sept. 25-28—American Hospital Association, Atlantic City, New Jersey.

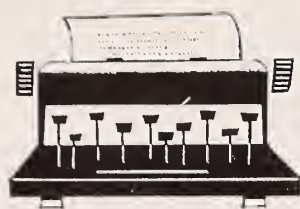
Sept. 30 - Oct. 3—College of American Pathologists, Seattle, Washington.

Sept. 30-Oct. 8—American Society of Clinical Pathologists, Olympic Hotel, Seattle, Washington.

Oct. 15-20—Fourth International Congress of Allergology, the Hotel Commodore, New York, New York.

Oct. 20-24—34th Annual Meeting, American Heart Association, Miami Beach, Florida.

Oct. 25-29—American Society of Clinical Hypnosis, St. Louis, Missouri.



editorials

Annual Session . . . Atlanta

ON BEHALF OF THE Fulton County Medical Society as host to the Medical Association of Georgia's 107th Annual Session, May 7-10, Atlanta, let me assure you that we are enthusiastic about the coming event. Our local committees are eagerly developing plans for an outstanding session.

Some 20 out-of-state guest speakers will highlight the scientific sessions. Approximately 50 of our own Georgia physicians will also present significant scientific papers.

Companion to the scientific sessions is the glow of happiness that gladdens us all in the warm hand-clasp of old friends and their wives—and the stimulus that comes from meeting and making new friends. The traditional President's Banquet promises fellowship, good food, and entertainment. The FCMS is happy to host a Social Hour for the entire MAG membership just prior to this banquet.

Georgia's 17 specialty societies have arranged luncheons and dinners throughout the meeting. In the cool of the evening after work is done, graduates and their wives will gather at alumni banquets. They will reminisce, give a new twist to old stories, and sip the wine of love and fellowship.

The Woman's Auxiliary has made great plans for their meeting. Our good wives, God bless them, will also enjoy a full social calendar of teas, tours, and shopping.

Each and every member of Fulton County feels a personal responsibility for making this session one of the most instructive and enjoyable meetings yet held. Come—and bring your wife—our welcome mat is out.

*J. G. McDaniel, M.D., President,
Fulton County Medical Society*

White House Conference on Aging

IN 1958 CONGRESS appropriated funds for the study of the problems on aging to be conducted in each state and territory. Each of these studies was to be correlated at the White House Conference on Aging. This conference was held in January, 1961 and representatives of the Medical Association of Georgia along with other appointees of Governor Vandiver attended as official delegates.

News items flooded papers in Washington and

throughout the nation just prior to this conference, boldly accusing medicine with "stacking" the conference sessions. As it turned out, this was far from the truth. Medicine was represented by only ten per cent of the total official delegates registered. It was most evident that medicine was far outweighed by other factions especially labor groups, government employees, bureaucrats, and social scientists. In the opinion of many present, the conference was

dominated unfairly by these segments. One gained the impression that many of these opposing groups were there to serve selfish purposes and not to study and make recommendations with the best interests of the senior citizens at heart.

While the White House Conference on Aging covered many facets of the aging problem, the section on Income Maintenance (financing the health care of the aged) was by far the most controversial. Various reports have publicly stated that the conference unanimously supported the social security mechanism as the best means of financing health care. Such was a gross misstatement of fact. In the voting sections the actual vote was only a 71 vote differential between the actions for and against such an approach. In the seven sub-groups of the Income Maintenance Section, five groups voted in favor of the social security mechanism by a difference of four to six votes in each group. One additional group was equally divided in opinion and the last group won the voluntary approach. This last subgroup was spearheaded by the Georgia delegation and fulfilled the official policy and charge given to it by the Medical Association of Georgia.

A strong minority opinion was voiced by the proponents of the voluntary approach and is as follows:

"It is our conviction that emphasis on the voluntary approach to the financing of health care, supplemented by adequate public assistance for those in need is the only method which is: (1) in accord with official expressions of the majority of State Conferences on Aging; (2) the one which allows complete flexibility of action to meet the changing health needs of the aged; (3) capable of utilizing

the immediate advantage of present legislation for a cooperative action of state and federal government; (4) the only one through which diverse segments of our society, including the individual, family, church, social organizations, employers both public and private, labor, and others can be encouraged to participate along with providers of health care, and (5) the only one which does not unnecessarily further burden the taxpayer.

"For these reasons, we believe that the Kerr-Mills Medical Aid for the Aged Law, passed by the last Congress, effectively meets the needs of those of the aged who need help and that proposed alternatives, under Social Security, are unnecessary and unwise."

It is high time that physicians throughout our state realized that labor has pledged its vast resources to defeat the voluntary approach, that much is being done to undermine the physician image to achieve this end, and that already a ruthless campaign is in force to vilify and downgrade medicine. There is no doubt in our minds that the establishment of the financing of the health care under the current social security concepts will eventuate in government control of medicine, hospitals, dentistry, nursing services, and nursing homes, in fact, all of the health care fields. Each physician must fight harder than he has before; he must fight at his local level as well as through his state and national organizations to combat this trend. Such a system represents more than "a foot in the door." It means the abolition of the private practice of medicine.

John S. Atwater, M.D., Atlanta

Aldosterone and Accelerated Hypertension

DESPITE THE INTENSITY of study of the physiology and pathophysiology of aldosterone, we are faced with more unknown quantities than facts. It may be said that aldosterone excretion is increased in the normal subject by those situations which decrease the effective extra-cellular water, for example phlebotomy, sodium restriction, and dehydration. On the other hand, salt loading and experimental water intoxication in normal subjects are associated with

decreased urinary aldosterone secretion. Experimentally, traction on the right auricle and obstruction of the inferior vena cava tend to augment the rate of aldosterone secretion, while carotid artery constriction or release of inferior vena caval obstruction decrease aldosterone elaboration. These latter responses are probably to some degree mediated through the autonomic nervous system.

Although it can be shown that aldosterone secre-

tion is stimulated by a humoral factor, this is apparently not corticotropin. In physiological states, at any rate, aldosterone is only to a minor degree dependent upon pituitary ACTH. In the clinic this is exemplified by the fair success with which pan-hypopituitary patients conserve sodium. In the laboratory this ACTH independence is supported by the work of Gordon Farrell, suggesting a midbrain center for the elaboration of aldosterone secreting hormone (glomerulotropin). Although for a brief time it appeared that glomerulotropin arises from the pineal gland, work from the laboratories of Altschule and Greep fails to demonstrate deviations in sodium and potassium metabolism induced by pinealectomy or administration of pineal extracts.

Progress has been hampered by the absence of reproducible, sensitive, and specific techniques for quantitating aldosterone secretion. Some years ago Stanley Ulick and Seymour Leiberman isolated a metabolite of aldosterone (tetrahydroaldosterone) in human urine. Ulick was able to adapt the measurement of tetrahydroaldosterone to allow the estimation of the dilution of administered radioactive aldosterone. The rate of dilution then allowed calculation of aldosterone secretion rates in patients.

Using this technique John Laragh and Ulick report normal subjects to secrete 250 micrograms per day of aldosterone while receiving a normal sodium intake. With salt loads this value falls to the 50 microgram per day range and with sodium deprivation this value reaches 1000 micrograms per day.

Aldosterone hypersecretion has been documented in cirrhotic ascites and nephrosis, but not consistently in patients with congestive heart failure. Laragh and his associates have shown that the majority of patients with benign essential hypertension secrete aldosterone at rates comparable to the normal subject. In some cases of hypertension secondary to unilateral ischemic kidney disease, and in the majority of patients with the accelerated phase of hypertension, one finds an increased rate of aldosterone secretion.

These studies in hypertensive patients then led to the investigation of various hypotensive and pressor agents with regard to the rate of aldosterone secretion.

Neither hexamethonium ganglionic blockade nor alpha methyl DOPA inhibition of production of norepinephrine and epinephrine altered the aldosterone secretion rate significantly.

Administration of epinephrine and norepinephrine to subjects on normal sodium diets yielded inconsistent results. Of 17 subjects given sodium restriction, 11 responded to the catechol hormones by decreasing aldosterone secretion rate. Epinephrine apparently effected this decrease more often than norepinephrine.

Eight studies of the infusion of the octapeptide angiotensin II were performed in six subjects. Regardless of sodium balance, angiotensin II effected increases in aldosterone secretion rate by 35 to 230 per cent of the control values.

These provocative studies would allow one to speculate that the following reactions might occur in patients with accelerated hypertension. Renin is released by the ischemic kidney. This enzyme then releases angiotension from a plasma globulin. This angiotension, or its metabolite, then stimulates the adrenal cortex in an unknown fashion to secrete increased amounts of aldosterone.

Balance data collected in these studies suggest that the altered aldosterone secretion rate effected by the pressor agents was independent of body fluid compartments. Unfortunately, this alleged stability of the volume of extracellular water was not documented by the appropriate studies, but must be inferred. Herein lies a glaring weakness of otherwise exciting experiments.

Much work must be done to confirm and extend the observations of Laragh's group. These concepts cannot yet be incorporated into our clinical routine. These studies do represent, however, a new frontier in the pathogenesis of certain forms of hypertensive vascular disease.

*Roy A. Wiggins, Jr., M.D.
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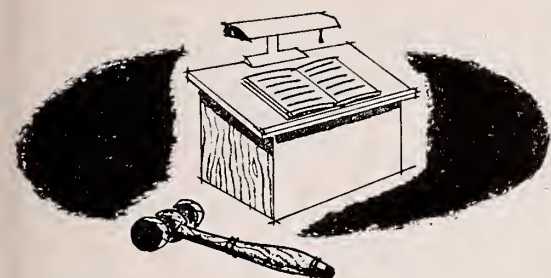
GEORGIA SOCIETY OF CLINICAL HYPNOSIS

THE GEORGIA SOCIETY OF Clinical Hypnosis met in Atlanta, January 8, for the Quarterly Meeting. Officers elected for 1961 were as follows:

President—Clifton Kemper, M.D., Atlanta
Vice President—Frederick Zuspan, M.D., Augusta

Secretary—George W. Vann, D.D.S., Atlanta
Treasurer—John T. Persall, M.D., Augusta
Membership Chairman—M. Kinstein, D.D.S., Madison

The next meeting will be Sunday, April 9, 1961 at 2:00 P.M. in the Cafeteria of Talmadge Hospital, Augusta.



president's letter

THE NEW FRONTIER IS IN YOUR BACK YARD

WITH THE INAUGURATION of President Kennedy and his Administration, we are faced with an ever-closer danger of medical care being administered by the Federal Government. Mr. Kennedy has made it clear that his chosen method of providing medical care for the aged would be under an expanded Social Security system, in spite of the fact that the last session of Congress passed the Kerr-Mills Bill which we, of the medical profession, believe would better meet the needs of the aged if the individual states and the medical profession give it their full cooperation. We, of the medical profession, face a continuing fight which will require our best efforts to prevent this opening wedge to the socialization of medicine becoming law in the very near future.

Your state officers and organization have during the last nine months contacted and conferred with our Senators and Congressmen and have been gratified by their understanding of our problem and their attitude toward this expanded Social Security measure. We have also talked with other officials, some in the new Kennedy administration, and have been assured of their willingness to hear our side of the story. Actually, they all protest any desire for socialized medicine, but they state that the Social Security tie-up would be merely a method of financing and not a means of federal control. However, it has been my observation that the one who controls the purse strings certainly calls the signals.

We of the MAG will continue to lend our best efforts to fight legislation which we feel tends toward federal control of the practice of medicine. However, perhaps in the final analysis, the case for or against the socialization of medicine will be decided



MILFORD B. HATCHER, M.D.

not by the members of Congress or the new Administration, *but by the American people themselves*. These people have quite a few criticisms to level at the medical profession, some of them perhaps justified, other quite unfair. The most commonly heard are the following: (1) that our charges are exorbitant in many instances, based more on the intangible importance of the procedure to the patient than on a reasonable valuation of our actual work; (2) that in collecting our accounts we tend to ignore the human elements of the situation such as weeks or months of unemployment and greater expenses. and (3) we try to run a doctor's office like a department store.

Another oft-repeated commentary on members of the medical profession is that they are fast becoming the nation's chief exponents of the art of 'conspicuous consumption.' As Vance Packard's "The Status Seekers" states, in any community the

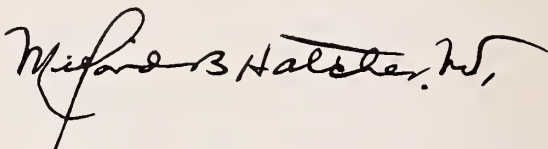
PRESIDENT'S LETTER / Continued

doctors far outnumber the other professions in living in the most expensive residential district, driving the most expensive cars, etc. The arguments and defenses of these are many: the long years of study, the years spent on less than adequate means, and the time at last when most members of the profession are able to afford the material advantages for themselves and their families. However, the public is somehow more prone to condone this "conspicuous consumption" in a family who has made its money selling insurance, bricks, etc., than, as they state it, "at the expense of someone else's misfortunes." Therefore, it behooves us of the medical profession to be extremely careful in this area, particularly when we are the target of so much criticism.

We must not be guilty, like many American in-

dustries today, of pricing ourselves out of the market and being unable to meet the competition of the proponents of socialized medicine. This, in the long run, will work to our own disadvantage.

In short, we, of the medical profession, are in a most critical period, as the "New Frontier" has moved into our own back yard. Each of us should realize our stake in the outcome of the current social changes and *not be guilty of either neglecting to do our part in combating the forces advocating more federal control or by actions of our own giving the American people reason to think that federally controlled medical care would be preferable to the kind we practice today.*



President, Medical Association of Georgia

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Barrow, Ben C.	Professional Bldg. Monticello	Active	Jasper
Chambless, Fred P.	205 W. Gaines St. Dublin	Active	Laurens
Gordon, Clarence F.	Floyd Hospital Rome	Active	Floyd
Hames, Frederick W.	Forsyth County Hospital Cumming	Active	Chattahoochee
Lane, Nell K.	924 Gordon Ave. Thomasville	DE-3	Thomas-Brooks
Lyon, James A., Jr.	P. O. Box 327 Edison	Active	Southwest Ga.
Miles, Marilynn L.	703 S. Main St. Moultrie	Active	Colquitt
Price, Quentin	205 W. Gaines St. Dublin	Active	Laurens
Randolph, Paul D.	327½ W. Jackson St. Thomasville	Assoc.	Thomas-Brooks
Wise, Samuel P.	V. A. Hospital School of Research Perry Point, Md.	Assoc.	Sumter



current clinical concepts

Plastic Reconstruction for Exstrophy of the Urinary Bladder

PLASTIC RECONSTRUCTION OF THE bladder and urethra, with closure of the abdominal wall and bony pelvis, and with protection of the upper urinary tracts is practical and should be successful. This procedure is preferable to diversion of the urinary stream and other makeshift operations.

Sweetser, Theodore H.: Plastic Reconstruction for Exstrophy of the Urinary Bladder, *S. Med. J.* 53:12 (Dec.) 1960.

Lightning Stroke

DEATH IS NOT ALWAYS immediate after lightning stroke, and effective action may be successful in restoring a virtually undamaged organism. The recovery may occur after considerable delay which recovery is beautifully reported in this exciting recovery.

Lightning Stroke, report of a case with recovery after cardiac massage and prolonged artificial respiration, *N. Eng. J. Med.* 264:1 (Jan. 5) 1961.

The Role of the Nonuniversity Hospital In Surgical-Resident Training

IT WOULD BE WELL for every physician to familiarize himself with this special article and its sequel. More than 75 per cent of all internships and residencies are in nonuniversity or nonuniversity-affiliated hospitals. The future of American medicine and surgery is dependent upon the type of training given in these nonuniversity institutions.

Standish, Welles A., M.D.: *N. Eng. J. Med.* 264, (Feb. 23) 1961.

Hemorrhagic Disease of the Newborn

HEMORRHAGIC DISEASE OF the newborn continues to be a poorly defined entity which is characterized by the occurrence of spontaneous bleeding from multiple sites between the second and fifth day of life.

Various deficiencies in coagulation may play some role in the pathogenesis of the disorder. Both vitamin K and whole blood transfusions have been found to be effective in the therapy of this disorder.

Ehling, L. Rex: Hemorrhagic Disease of the Newborn, *Am. J. Dis. Child.* 101:241, 1961.

Duodenal Ulceration and Fibrocystic Disease

HEMATEMESIS IN CYSTIC fibrosis of the pancreas most commonly suggests portal hypertension. This report concerns a small child with advanced cystic fibrosis with development of ulcerations of the duodenal mucosa leading to fatal hemorrhage.

Aterman, K.; Duodenal Ulceration and Fibrocystic Pancreas Disease, *Am. J. Dis. Child.* 101:210, 1961.

The Limitations of Pathology

SOME YEARS AGO, when one of the ablest pathologists of this generation was asked how he would rate himself on the identification of malignant tumors, he replied that, if he could accurately identify 85 per cent of them, he would consider this a satisfactory percentage. If this is an approximation of the truth, there must be many pathologists who cannot do better than 75 per cent. With a margin of possible error ranging between 24 per cent and 15 per cent, it must be admitted that such a margin is sufficient to make one shudder at the

plight of those in whose cases the errors are made, because some of these errors could have tragic consequences.

Desjardins, A.U.: Is the Pathologist Infallible? Arch. Int. Med. 106:596, 1960.

Errors in Lymph Node Biopsy

IN THIS STUDY THE enlargement of superficial lymph nodes was frequently associated with serious, and often fatal systemic disease. This was true even after excluding those patients in whom a histopathologic characteristic of a specific disease was made. In 158 patients in whom the histopathologic diagnosis of the lymph node was not helpful to the clinician, 26 developed "Collagen disease," and 37 malignancy. Forty-seven of the 158 patients are living and well. Fifty-five patients in this study are dead; the average time of survival was 13 months after biopsy. Therefore, a patient with lymphadenopathy unexplained by biopsy deserves long-term careful observation on the part of the clinician.

Moore, R. O.; Weisberger, A. S., and Bowerfind, E. S., Jr.: An Evaluation of Lymphadenopathy in Systemic Disease, Arch. Int. Med. 99:751, 1957.

Renal Arterial Insufficiency Causing Hypertension

FOLLOWING COMPLETE EVALUATION OF the kidneys in hypertension, indicated surgical intervention should include adrenal gland exploration as well as exploration and measurement of arterial pressures of the renal arteries and bilateral renal biopsies.

DeCamp, Paul T.: Renal Arterial Insufficiency Causing Hypertension, Surg., Gyn., & Obst. 112:1, (Jan.) 1961.

Gout

THE PAIN OF ACUTE gouty arthritis has been variously described by many of its victims, but perhaps the most frequently quoted word picture is due to the early nineteenth-century cleric and wit, Sydney Smith: "When I have gout, I feel as if I am walking on my eyeballs."

Stetten, D., Jr.: Gout-Perspective in Biol. and Med. 2:185, 1958-59.

The Familial Nature of Gout

Lazy Tom with jacket blue,
Stole his Father's gouty shoe.
The worst harm that Dad can wish him,
Is his gouty shoe may fit him.

Mother Goose.

Renal Function and Infection in Advanced Bladder Cancer

ALTHOUGH DIVERSION OF THE urinary results in no significant improvement in renal function, the procedure is quite effective in providing prompt relief of the distressing symptoms of bladder cancer and facilitates irradiation therapy.

Levin, Jack, et al: An Appraisal of Renal Function and Infection in Advanced Bladder Cancer Treated with Ileal Bladder Construction and Irradiation, Surg., Gyn., & Obst. 112:1, (Jan.) 1961.

Urologic Problems in Carcinoma of the Cervix

PROGRESS IN BOTH IRRADIATION and surgical management of carcinoma of the cervix has significantly affected the need for close cooperation between the gynecological surgeon and the urologist. An evaluation of the urinary tract should be carried out before surgery and careful care of the same tract after surgery.

Kickham, Charles J.E.: Urologic Problems in Carcinoma of the Cervix, Surg., Gyn., & Obst. 112:1, (Jan.) 1961.

Medical Association of Georgia Annual Session

May 7-10, 1961

Atlanta Biltmore Hotel

Atlanta, Georgia



Legal page

PROFESSIONAL ASSOCIATIONS

John L. Moore, Jr., *Atlanta*

FOR SEVERAL YEARS PROFESSIONAL groups including doctors, lawyers, accountants, and architects who are all prohibited from practicing their professions through the means of a corporation have worked toward obtaining recognition by the Internal Revenue Service of a kind of business association taxable as a corporation. Such a professional association would enable professional group practitioners to achieve some of the advantages available to employees of a corporation while not transgressing the ethics of the professions. Along with the benefits would go the burdens of separate corporate income taxation.

The specific advantages available if a professional association is taxable as an "association," meaning taxed as a corporation is taxed, are deductibility by the group of premiums paid for group hospital and medical coverage, health and accident insurance, and group life insurance without any tax consequence to the employee. Particularly important would be the deductibility of contributions to tax exempt pension and profit sharing plans covering employees of the group. If the group were taxable as an association, the term "employees" would include those who, under present law, are considered "partners" and not "employees."

The pioneers in this struggle were a group of doctors in Montana. In 1954, they won their battle for recognition of the group as an association al-

though the Internal Revenue Service had fought them through all of the courts. The Internal Revenue Service has resisted the implications of the *Kintner* case of 1954 and, pursuant to that policy, did not issue regulations under the relevant section of the Internal Revenue Code until November 15, 1960. The practical effect of the Regulations, at least in Georgia and probably in most states of the Union, is to block professional groups from qualifying for taxation as an association. However, the Regulations refer to local law. The result is a series of bills in various legislatures over the country to change local law in such a way as to enable professional groups to be taxed as associations.

The Regulations require a professional group's organization, if it is to be taxed as an association, to have a preponderance of certain characteristics of a corporation as distinguished from a partnership. The important characteristics are continuity of life of the group irrespective of the life of the individual members, centralization of management, limited liability, and free transferability of shares.

Under the existing law of partnership in Georgia, it is extremely doubtful whether any of those features could be obtained. At this writing there is before the Georgia General Assembly of 1961 a bill intitled "The Georgia Professional Association Act," identified as Senate Bill 92. This bill, similar in form to bills introduced in other states of the Union,

Prepared at the request of the Medical Association of Georgia. Mr. Moore is an associate in the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.

allows professional groups to form an unincorporated association simply by filing copies of the Articles of Association in certain official offices and paying a filing fee. The bill provides that the Articles of Association may cause the association's life to continue irrespective of the life of the particular members or employees. It provides for the required free transferability of interest only restricted by the fact that the shares may be transferred only to others who are licensed to practice the particular profession. Also, the shares may be subject to a right of first refusal in other members or shareholders of the association. While the bill specifically provides that past rules as to professional liability shall continue in effect, the individual members of an association are not personally responsible for the debts of the association. The bill further allows for

centralized management in a Board of Governors to be elected by the shareholding members.

It is believed that, if Senate Bill 92 is passed into law, professional group practitioners may obtain the very substantial tax benefits previously enjoyed only by business men who could incorporate. At the same time the vital ethical requirements of the direct relationship with patients or clients will not be disturbed. The public will be protected by a full disclosure of the terms of the association by the filing of the Articles in public offices.

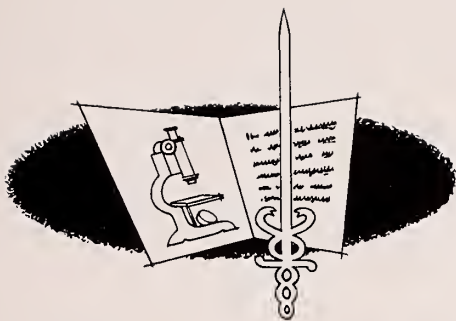
Should Senate Bill 92 fail to pass at this session of the Georgia General Assembly, it is almost certain that the same bill or a similar bill will be introduced at a later time. In the meantime, it is likely that several other states in the United States will pass legislation enabling professional group practitioners to obtain some of the tax benefits mentioned in this article.

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cancer page

PALLIATIVE CANCER THERAPY

Hoke Wammock, M.D., *Augusta*

IT IS REPORTED THAT a breakthrough in the cause and cure of cancer may be imminent. However, until this occurs, we must continue to utilize all available means for both curative and palliative effects. Fifty per cent of all cancers could be cured if recognized early and proper therapy applied. Unfortunately, the curability rate approximates about 33 per cent. This leaves us with an approximate figure of 66 per cent of cancer patients requiring some type of palliative therapy. Palliation means: to lessen the gravity of, to extenuate, to reduce the severity of, to mitigate, and to cure temporarily, as disease. Hence, the greater portion of our therapy is administered on a palliative basis. In administering palliative therapy, the patient may be subjected to altered physiological function and sometimes to psychological trauma.

In planning therapy, we must analyze each individual case, taking into consideration the anatomical site, the histological type, metastatic potential, lethal potential, and host-tumor relationship. We, of course, should endeavor to cure wherever possible, but there are a great many instances where curative therapy is attempted, and much to our astonishment we find it is only a palliative procedure, and some-

times relatively poor palliation at that. We must first ask ourselves if the therapy under consideration will delay activity of the disease, or whether it will contribute to the discomfort of the patient or even hasten his demise. The purpose of palliative therapy, then, is to maintain as near as possible normal bodily functions to reduce pain, to delay tumor activity, and to mitigate suffering.

Today our armamentarium of cancer therapy consists of advancing radical surgery, supervoltage irradiation, and chemotherapeutic compounds. The proper selection of one of these or a combination of these modalities should add to the comfort of the patient and delay the activity of the tumor. We of course know that the more radical a surgical procedure may be for a less curable disease, the higher the mortality and morbidity. There, of course, are cases where removal of the primary lesion in face of metastasis may sometimes offer palliation to the patient. This is in carcinoma of the rectum with metastasis to the liver, or in cases of malodorous and ulcerating lesions in carcinoma of the breast with metastasis. Unfortunately, radical surgery for carcinoma of the esophagus, stomach, and lung has a poor survival rate. At best it is no more than

Approved by Professional Education Committee, Georgia Division, ACS.

seven per cent in those apparent curable lesions.

A good example of palliation is carcinoma of the prostate with bone metastasis. Here the victim is not subjected to a radical prostatectomy, but is treated by hormonal therapy, and in a great many instances by a combination of orchiectomy and the administration of estrogenic substances. Carcinoma of the ovary is usually recognized in the majority of instances when the disease has metastasized or implanted on contiguous structures. Carcinoma of the ovary can be palliated very well with chemotherapeutic compounds and deep therapy after removal of the primary growth.

An operative procedure that can be performed in continuity with both the primary and the secondary lesion deserves careful evaluation. This is particularly true if the lesion arises around the oral cavity and the head and neck section. These composite operations oftentimes result in the saving of lives of a few individuals, but unfortunately many of those fall into the incurable group and their suffering may be increased. For lesions arising in this area, very careful consideration must be given to the type of therapy to be employed, whether the lesion for

consideration is potentially curable or incurable, and, based upon this decision, the kind of therapy to be employed must be weighed very heavily.

There has been considerable advancement of knowledge up to the present time in the application of regional perfusion on a selected arterial distribution of the compound to the primary and metastatic site. This has lead to the relief of pain and discomfort in some cases, but unfortunately, some patients have succumbed to this plan of therapy. However, mortality will be reduced as we gain further knowledge of the application and the lethal potential of these chemical compounds.

It is not within the scope of this discussion to cover palliative therapy in its entirety, but it is very necessary and important for us to stop and reflect on each individual case before embarking on a plan of therapy. Every phase of each particular problem should be thoroughly analyzed. It requires the combined effort of the surgeon, the radiologist, and those interested in chemotherapy to select modalities or combinations in order to utilize the most effective means of palliating the individual suffering from incurable cancer. By the cooperation of all concerned, it is hoped that the patient will receive maximum comfort from whatever type of therapy may be selected.

KISER GIVEN MAG TOKEN OF APPRECIATION



Left to right, John T. Mauldin, MAG Secretary; Milford B. Hatcher, MAG President; Mr. John F. Kiser, former MAG Associate Executive Secretary; Mrs. Kiser, and J. G. McDaniel, MAG Council Chairman. Mr. and Mrs. Kiser are shown receiving engraved silver tray presented by the MAG.

IN AN INFORMAL CEREMONY, the officers of The Medical Association of Georgia presented Mr. and Mrs. John F. Kiser with a token of the Association's appreciation for outstanding service rendered by Mr. Kiser as Associate Executive Secretary for the years 1953-61.

Mr. Kiser resigned this position with the Association, effective February 1, 1961, to assume a position on the Field Service staff of the American Medical Association, Chicago.

In addition to his duties as Associate Executive Secretary, Mr. Kiser staffed the Medical Association of Georgia Legislative Committee, History and Vital Statistics, Mental Health, Professional Conduct, Public Service, Weekly Health Column, School Child Health, and others too numerous to name.

Mr. and Mrs. Kiser will reside in Wilmette, Illinois, a suburb of Chicago. In Mr. Kiser's new position, he will be headquartered in Chicago at the American Medical Association central office and serve six New England states under his AMA Field Staff assignment.



heart page

FATS AND CORONARY ARTERY DISEASE

Philip T. Rodilosso, M.D., *Atlanta*

ATHEROSCLEROSIS COULD BE CONSIDERED as the result of time and a disordered fat metabolism. There is much evidence that the disordered fat metabolism is a result of dietary causes. This explanation, of course, is not accepted by all.

The relationship of diet to atherosclerosis was probably first considered on account of the sharp drop in mortality in Scandinavia during World War II. By reason of the rationing of butter, eggs, and cheese, the focus was put on the role of fats in the diet. Also, differences in mortality were noted between countries using different kinds of fats. Danes, with low mortality and high fat intake, used mainly liquid oils, while Finns, with a high mortality but lower fat intake, used practically all solid fat.

Genetic factors have been considered one of the determinants. However, comparisons of the same race living under dissimilar environmental conditions show that with increasing prosperity and its usual increases in dietary fats, there is an increasing incidence of coronary artery disease. This has been seen in studying Japanese who are living in California and Hawaii and Yemenite Jews who have migrated to Israel.

An increasing fat consumption more easily explains the rising rate of coronary artery disease in the United States than it does in Britain, but there are many other subtle changes, such as an increase in consumption of saturated fats and a decrease in

polyunsaturated fats. Also, fatty acid composition of the animal fat is dependent on what the animal eats.

The great difference between the sexes in coronary artery disease is noted only in areas where the incidence of coronary artery disease is high and the fat intake is high. This brings up the possibility that the female can metabolically handle her dietary fat better than the male.

There is good evidence for the relationship between diet and serum cholesterol. But, it has not yet been shown that the dietary effects on serum lipid levels have any effect on the degree of atherosclerosis. Also, there is no proof that the severity of aortic atherosclerosis parallels that in the coronary artery. In atherosclerosis the sex difference at post mortem is not as great as in myocardial infarction.

Studies on atheromatous plaques have shown that lipid is deposited from the serum and that the arterial wall is capable of synthesizing cholesterol. In animal studies there has been a close relationship between changes in diet and atherosclerosis, but these are artificial lesions produced over a short period of time. Therefore, animal experiments do not necessarily reflect the disease in man.

The cholesterol-lipoprotein complex is the most commonly discussed serum lipid. Probably the most frequent laboratory determinations have been the serum cholesterol. In groups where there are wide

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

differences in the incidence of coronary artery disease, there are significant differences in the mean cholesterol. But, in homogeneous groups and in clinical practice, there is considerable overlap between normals and coronary artery disease patients.

Phospholipids are considered as possible stabilizers of cholesterol in solution. This brought about the use of cholesterol-phospholipid ratio which is higher in coronary artery disease than in normals, but again the overlap is quite considerable.

Lipoproteins have been divided into alpha and beta fractions. With increasing age, masculinity, and coronary artery disease, there seems to be an increase in the cholesterol in the beta fraction.

Triglycerides also have been considered as the important lipid factor in atherosclerosis. Fairly recent studies have suggested less overlap between coronary artery patients and controls when triglyceride levels were used rather than serum cholesterol.

The effect of lipids on blood coagulation is a very controversial subject. The only agreement is that the plasma stypven time is shortened after a high fat meal. Also, there have been no consistent results in studies in fibrinolysis.

Earlier studies showed different effects of animal versus vegetable fat on serum cholesterol. But more recent studies have revealed that this effect was not due to the animal or vegetable fat, but due to the fatty acid content of the fat. Fats that contain the more saturated fatty acids raise the serum cholesterol, whereas the polyunsaturated fatty acids lower the serum cholesterol. These effects will persist as long as the fatty acid is fed. The mechanism

for the effects of the fatty acids is not well understood. On feeding high iodine value oils, there is a sharp increase in bile acid excretion. This suggests a fast turnover rate for cholesterol. Since, in animals, the polyunsaturated fatty acids seem to be necessary for the metabolism of the more saturated fatty acids, essential fatty acids have also been considered as the important lipid factor in atherosclerosis. The effect of dietary cholesterol on serum cholesterol has not been decided. However, experiments on egg fractionation have shown that the serum cholesterol rise produced by feeding both the cholesterol and fatty acid content of the egg yolk together is significantly much higher than if either is fed alone.

Another theory on the mechanism of the fatty acids is that the raising or lowering effects of a fat parallels its solubility for cholesterol. As the saturation of the fatty acid increases, so does its solubility for cholesterol. Therefore, it is postulated that the serum cholesterol raising effect of a highly saturated fat, such as coconut oil, is due to its high solubility for endogenous cholesterol.

The serum changes following the feeding of dietary fats have been fairly consistent as has been shown in many epidemiological studies. Populations that eat low fat diets have low serum lipids and the converse is also true.

In conclusion, it can be said that lipids are a major constituent of atheromatus plaques, that serum lipids are related to dietary fats, and that changes in dietary fats cause changes in serum lipids; however, it has not yet been proven whether these differences have any bearing on coronary artery disease or atherosclerosis.

American Medical Association

Annual Meeting

June 25-30, 1961

New York Coliseum

New York City



mental health page

THE HYPOMANIC STATE

Joseph S. Skobba, M.D., *Atlanta*

HYPOMANIA IS THE MILDEST form of the manic phase of the manic-depressive reaction. The excessive and uncontrolled behavior of the individual involved prompts the family to call upon the family physician for help. Pleased at first by the pleasant mood of the person, the family is bewildered by the rapid development of distressing and embarrassing behavior: excessive and monopolized conversation, excessive activity, quarreling, lavish expenditures (often without regard for the financial situation), reckless driving, and possibly alcoholism.

The individual attack often is preceded by a short depressive episode. This may be so transient that it is not noticed by the patient or by those around him. There may be only a loss of appetite or a feeling of exhaustion.

The outstanding change in hypomania is in the mood. There is a feeling of extraordinary well-being manifested by cheerfulness and affability. There may be frequent exclamations such as "I feel like a million dollars," or "I never felt better in my life!" Too often those about the patient are pleased by this situation, especially if the individual had been depressed for any appreciable time. As a result, it is difficult for those who are aware of the pathological and serious nature of this apparently desirable state to convince relatives (whose cooperation is vital) that hospitalization or commitment is necessary. The elated mood prevails unless there is an effort to restrict the patient or interfere with the expansive activities. Under these conditions the pa-

tient becomes irritable and angry and may become combative. The greatest degree of skill and tact may be necessary to obtain cooperation. Efforts to control or advise the patient may produce hostility toward members of the family and others.

Thinking processes in the hypomanic are accelerated and the mind becomes very fertile with expansive ideas. There are varying degrees of distractibility, and this may be used in the management of the individual who at this stage is witty, nimble in argument, and in the production of excuses with considerable disregard for the truth. There may be a slight paranoid coloring to the complaints and protests against those attempting any control. This is often accepted as bona fide by those who have been deceived by the prevailing pleasant mood and convincing manner. It is only when they themselves are confronted with the responsibility for the person and find that the behavior is unconventional and uncontrollable that they rapidly agree to definite action towards control.

The attitude of the patient is one of great confidence and self assurance. There is increasing assertiveness. In the daily pattern of life the individual is bored with the routine. He plans expansive enterprises. When one is begun he becomes distracted by the next one and loses interest in the first. Money is spent extravagantly, and this may lead to the writing of checks beyond the limit of the bank account. Extensive purchases are likely; there is much telephoning, perhaps installation of

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

additional 'phones. There may be extensive travel, especially by plane. When an effort to control is exerted, the patient becomes very intolerant of criticism and very argumentative in defending the action. The over-spending or over-buying may lead to serious financial embarrassment, both personal and corporate, if the patient occupies a position of authority.

The hypomanic person is bursting with energy. His activity keeps him up late and there is no need for sleep so he awakens early to begin the busy activities of the day. There is little time for food—the interruption for eating is considered an interference in the busy schedule. Behavior becomes unconventional. Conversation is indiscreet. Personal and private matters are discussed freely with strangers. The erotic impulse may be increased with resulting sexual excesses and promiscuity.

The episode lasts several weeks or months and terminates in the restoration of normal functioning. The attack may be a single isolated episode, or there may be recurrences and these may be preceded or followed by episodes of depression.

The milder type of this reaction is likely to be very troublesome since deviation from the normal is not great and the patient may at times voluntarily curtail his overactivity when the occasion demands. Associates and others in brief contact see only normal or excusable buoyancy and exuberance in patients whose actual abnormal behavior is keen-

ly felt by the friends and the family who must live with it day in and day out. There is nothing more trying to live with than persistent hypomanic elation and push to activity. The more marked types create no doubts concerning the need for treatment. The patient himself sees no need for treatment as he "never felt better in his life!"

The family physician may be the only individual with sufficient influence to succeed in having the patient accept restrictions and to take offered medication. The phenothiazines are generally effective in reducing the activity. The patient feels the retardation produced by the medication and is unwilling to accept it in view of the pleasant mood that he enjoys without the medication. If the patient can be persuaded to take the medication in adequate doses, the condition can be controlled and hospitalization or commitment may be avoided. Chlorpromazine is one of the medications which may be used in doses of 50 mg. four times daily; this may need to be doubled. The known contraindications and complications must be kept in mind. If the medication in this dosage fails, or the patient is unwilling to take it, then either hospitalization or commitment is indicated. Electroshock treatment may be necessary. The patient must be carefully observed for signs of depression for occasionally there is an almost immediate onset of depression. Depression may follow after a short interval of normalcy.

The prognosis for the individual attack is excellent. Recurrence is common. The personality remains intact.



**Medical Association
of Georgia
Annual Session
Headquarters**

**Atlanta Biltmore Hotel
Atlanta, Georgia
May 7-10, 1961**

Mark These Dates on Your Calendar

MAY 7-10, 1961

These are the dates for the

ANNUAL SESSION

of the

**MEDICAL ASSOCIATION
OF GEORGIA**



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Medical Association of Georgia 1961 Annual Session

May 7, 8, 9, and 10, 1961, Atlanta

A Housing Bureau has been established for your convenience in making your hotel reservations in Atlanta for the 1961 ANNUAL SESSION of the Medical Association of Georgia. Comparable room rates are listed. Use the Reservation Blank below. Please specify your first, second, and third choice hotel or motel. All requests for reservations should give: (1) anticipated date and hour of arrival; (2) date and approximate hour of departure, and (3) names and addresses of all persons who will occupy the accommodations. ALL RESERVATIONS MUST BE CLEARED THROUGH THE HOUSING BUREAU. Since all requests for rooms will be handled in chronological order, you should mail your application as early as possible. All reservations will be confirmed.

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THE NAME OF EACH HOTEL GUEST MUST BE LISTED. Include the names of all persons for whom you are requesting reservations and who will occupy the room(s):

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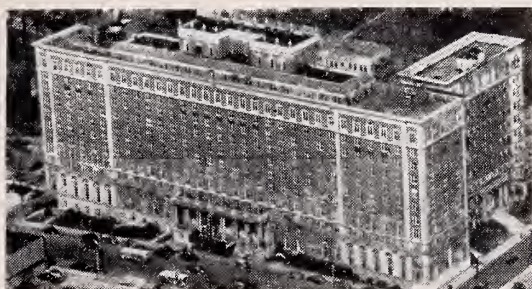
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If the hotels or motels of your choice are unable to accept your reservation, the Housing Bureau will make reservations to fit your specifications elsewhere.

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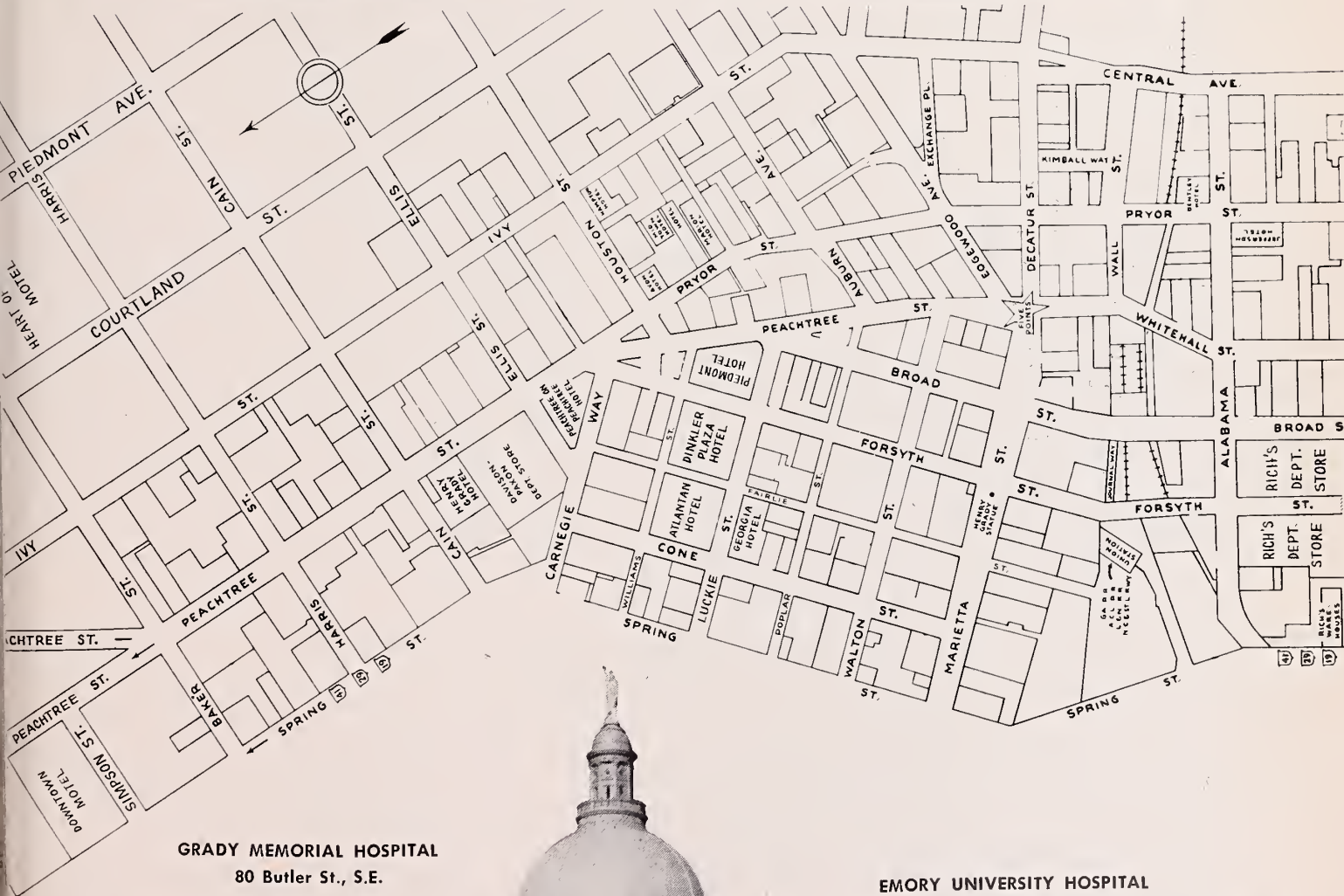
107th Annual Session, May 7-10, 1961



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1364 Clifton Rd., N.E.



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OFFICIAL CALL

extended to all Officers and Members of the Medical Association of Georgia

THE 107TH ANNUAL SESSION of the Medical Association of Georgia will be convened at the Atlanta Biltmore Hotel, Atlanta, Georgia on May 7, 8, 9, and 10, 1961.

The MAG Official Registration Desk will be located at the entrance to the Exhibit and Main Meeting Room located on the street level floor of the Biltmore. Registration for Association members and guests will be conducted Sunday, May 7 from 1:00 P.M. to 6:00 P.M.; Monday, May 8 from 8:00 A.M. to 5:00 P.M., and Tuesday, May 9 from 8:00 A.M. to 5:00 P.M.

General Business Sessions

The Association will convene the First General Business Session Sunday, May 7 at 2:00 P.M. in the Main Meeting Room for the purpose of nominations to MAG offices and awards. The Second General Business Session will be held Monday, May 8 at 12:00 noon in the main meeting room, at which time the outgoing MAG President will make his report to the membership and the MAG President-Elect will outline his program for the coming year. The Third General Business Session is set for Wednesday, May 10 at 11:00 A.M. in the Main Meeting Room. At this final meeting, MAG awards are presented, new officers installed, and the entire Annual Session is adjourned.

House of Delegates

The First Session of the Association House of

Delegates will be convened Sunday, May 7 at 5:00 P.M. in the Main Meeting Room, at which time all reports and resolutions will be introduced for referral to reference committees. The Second Session of the House of Delegates will be held Wednesday, May 10 at 9:00 A.M. in the Main Meeting Room. Reference Committees will make recommendations on all reports and resolutions before the House and final action will be taken by the members of the House on all MAG business.

Scientific Meetings

Foremost of all the scientific section and joint section meetings is the General Scientific Session (G.P. Day) to be held Tuesday, May 9 from 9:00 A.M. to 12:00 noon and to reconvene again in the afternoon from 2:30 P.M. to 5:00 P.M.

Another highlight of the scientific program is the Abner W. Calhoun Memorial Lectureship which will be held Tuesday, May 9 at 12:00 noon in the Main Meeting Room.

Scientific Section and Joint Section meetings are scheduled for Sunday afternoon, May 7 from 2:30 P.M. to 5:00 P.M.; Monday morning, May 8 from 9:00 A.M. to 12:00 noon; Monday afternoon, May 8 from 2:30 P.M. to 5:00 P.M., and all day Tuesday, May 9 as noted above. Meeting rooms for each section or joint section meeting are noted below and in the complete program listing.

PROGRAM BRIEF

Sunday, May 7

- 2:00 P.M. MAG General Business Session, *Main Meeting Room*
- 2:30 P.M. Pediatrics and Psychiatry Joint Section Meeting, *Main Meeting Room*
- 2:30 P.M. Radiology Section Meeting, *Mezzanine Rooms 14 and 15*
- 2:30 P.M. Orthopedic Section Meeting, *Mezzanine Room 10*
- 2:30 P.M. EENT and Anesthesiology Joint Section Meeting, *Auditorium, Academy of Medicine*

- 4:40 P.M. Georgia Society of Ophthalmology and Otolaryngology Business Session, *Academy of Medicine, 875 West Peachtree Street, N.E.*
- 4:40 P.M. Georgia Society of Anesthesiologists Business Session, *Academy of Medicine, 875 West Peachtree Street, N.E.*
- 5:00 P.M. House of Delegates Meeting, *Main Meeting Room*

Monday, May 8

- 8:00 A.M. Reference Committees 1, 2, and 3 Convene, *Rooms to be Announced*

9:00 A.M. Surgery, Anesthesiology, and Radiology Joint Section Meeting, *Main Meeting Room*

9:00 A.M. Medicine, Diabetes, and Dermatology Joint Section Meeting, *Georgia Ballroom*

9:00 A.M. Urology, Obstetrics, and Gynecology Joint Section Meeting, *Mezzanine Room Center*

9:00 A.M. Pediatrics and Psychiatry Joint Section Meeting, *Mezzanine Room 10*

9:00 A.M. Georgia Association of Pathologists Business Session, *Mezzanine Rooms 5 and 6*

12:00 NOON MAG General Business Session, *Main Meeting Room*

2:30 P.M. Reference Committees, 4 and 5 Convene, *Rooms to be Announced*

2:30 P.M. Chest, Radiology, and Medicine Joint Section Meeting, *Main Meeting Room*

2:30 P.M. Surgery and Urology Joint Section Meeting, *Georgian Ballroom*

2:30 P.M. Obstetrics and Gynecology Section Meeting, *Mezzanine Room Center*

2:30 P.M. Pediatrics and Orthopedics Joint Section Meeting, *Mezzanine Room 10*

2:30 P.M. Pathology Section Meeting, *Mezzanine Rooms 5 and 6*

Tuesday, May 9

9:00 A.M. General Scientific Session (G. P. Day), *Main Meeting Room*

12:00 NOON Abner W. Calhoun Memorial Lectureship, *Main Meeting Room*

2:30 P.M. General Scientific Session (G. P. Day) Reconvened, *Main Meeting Room*

Wednesday, May 10

8:30 A.M. Medical-Legal Workshop, *Auditorium, Grady Hospital, 80 Butler Street, S.E.*

9:00 A.M. House of Delegates Second Session, *Main Meeting Room*

11:00 A.M. MAG General Business Session, *Main Meeting Room*

Information

Registration

The Medical Association of Georgia official registration desk will be located at the entrance to the Exhibit and Main Meeting Room on the street level floor of the Biltmore. It will be open for registration of Association members and guests 1:00 P.M. to 6 P.M. on Sunday, May 7 and from 8:00 A.M. to 5:00 P.M. on Monday, May 8 and Tuesday, May 9. Members and guests are requested to register at the MAG registrations desk *immediately on arrival* to obtain badges and programs. *No one* will be admitted to the exhibit room and meeting rooms without official registration badges.

Message Center and General Information

A message center will be maintained at the MAG official registration desk for the convenience of the membership. Pages from the Woman's Auxiliary to the MAG will staff this center during the entire session. All notices of an official nature will be posted on the official bulletin board at the message center adjacent to the MAG registration desk.

Headquarters Office and Press Room

The MAG Headquarters Office Staff will maintain the Headquarters Office Room at the Atlanta Biltmore Hotel for the purpose of secretarial and staff activity in conjunction with the business of the Association.

An MAG Press Room will also be open during

the entire Annual Session for use by newspaper, radio, and television personnel.

House of Delegates

The MAG House of Delegates will convene at 5:00 P.M. Sunday, May 7 in the Main Meeting Room of the Atlanta Biltmore Hotel. MAG Delegates will reconvene for the Second Session of the House at 9:00 A.M. Wednesday, May 10 in the Main Meeting Room of the Biltmore.

All MAG Delegates are requested to attend both of these sessions of the House *15 minutes prior to the time they convene* so that the Delegates may be registered without delay of the meeting. Delegates registration will be conducted just outside the entrance to the Main Meeting Room.

Memorial Service

The Medical Association of Georgia will hold its annual Memorial Service at the opening session of the House of Delegates at 5:00 P.M., Sunday, May 7 in the Main Meeting Room. All members are cordially invited to attend. This service is held in memory of the members who have died during the past year.

Charles Ross Adams, Atlanta, April 20, 1960

W. A. Arnold, Atlanta, January 9, 1961

Lewis Beason, Butler, August 8, 1960

Peyton Elliott Bell, Sylvester, February 11, 1960

G. L. Broadrick, Dalton, December 6, 1960

Information

J. G. Carter, Scott, April 21, 1960
Bethel Bryant Chandler, Lula, October 19, 1960
William C. Cook, Columbus, October 13, 1960
William R. Dancy, Savannah, September 14, 1960
George William Dupree, Gordon, September 17, 1960
George Lee Echols, Milledgeville, October 23, 1960
E. L. Evans, Tifton, December 3, 1960
Clayborne Anderson Harris, The Rock,
October 17, 1960
John H. Hines, Roswell, May 28, 1960
Charles A. Hodges, Dublin, December 4, 1960
William Henry Houston, Colquitt, August 8, 1960
Lee Howard, Savannah, December 14, 1960
Thomas Cornelius Jefford, Sylvester, October 16, 1960
Jabez Jones, Savannah, December 31, 1960
James Benjamin Kay, Byron, June 25, 1960
Spencer A. Kirkland, Atlanta, December 29, 1960
John Tinkhan Manter, Augusta, November 5, 1960
W. P. Martin, Summerville, January 10, 1961
W. R. McCall, LaGrange, May 27, 1960
W. Edgar McCurry, Hartwell, October 28, 1960
J. L. Mitchell, Decatur, January 23, 1960
William Daniel Mixson, Waycross, June 2, 1960
Q. A. Mulkey, Millen, April 7, 1960
Weldon E. Person, Atlanta, May 14, 1960
James Carl Pirkle, Milledgeville, September 14, 1960
B. O. Quillian, Douglas, January 17, 1961
Hubert Rawiszer, Atlanta, May 2, 1960
W. H. Roberts, Augusta, February 15, 1961
John E. Saade, Augusta, November 20, 1960
William Asberry Sewell, Rome, June 22, 1960
William Walter Sharpe, III, Alma, November 16, 1960
David Marion Silver, Augusta, June 14, 1960
William Kirk Swann, Covington, August 29, 1960
John L. Taylor, Franklin, July 18, 1960
W. H. Whittendale, Norman Park, November 10, 1960
M. E. Winchester, Brunswick, December 24, 1960
Y. Harris Yarbrough, Milledgeville, October 24, 1960

Specialty Society Luncheons and Dinners

Specialty Societies have planned luncheons and dinners for the members of their organizations to be held in conjunction with the MAG Annual Session. These luncheons and dinners are scheduled for Sunday afternoon and evening, May 7 and Monday and Tuesday afternoons, May 8 and May 9. These events are listed in the official program even though they are not a part of the official program—in order of date, time, and place, under Social Events.

Woman's Auxiliary

The Woman's Auxiliary to the Medical Association of Georgia will have its Registration Desk in the Empire Foyer of the Biltmore Hotel. Auxiliary meetings will be held in the Empire Room at the Biltmore Hotel. The Auxiliary Desk in the Empire Foyer of the Biltmore Hotel will be opened Sunday, May 7 from 11:00 A.M. to 5:00 P.M.; Monday, May 8 from 8:30 A.M. to 3:30 P.M., and Tuesday, May 9 from 9:00 A.M. to 12:30 P.M. The complete

program giving the times and locations of the meeting of the 36th Annual Meeting of the Woman's Auxiliary to the Medical Association of Georgia will be found in this issue immediately following program material for the MAG.

Social Events

Information about social events planned in conjunction with the MAG Annual Session and the necessary tickets will be available at the MAG Annual Session and the necessary tickets will be available at the MAG official registration desk. As accommodations for such social events are limited, your cooperation in purchasing these tickets at the time you register is requested. The traditional Alumni Banquets and invitations to President's Banquet will be arranged at the registration desk.

Scientific Exhibits

Scientific Exhibits will be displayed adjacent to the commercial exhibits in the Main Meeting Room. These exhibits are of great interest to the membership and are prepared by physicians who will be on hand to discuss their exhibit with you. All members are urged to visit each scientific exhibit in the interest of professional education. A list of the scientific exhibits is as follows:

"The Systemic Therapy of Pyoderma": E. Randolph Trice, M.D. and Marshall Cohen, M.D., Richmond, Virginia.

"Forefoot Imbalance and Its Complications": Georgia Podiatry Association, Atlanta, Georgia.

"Various Applications of an Interposed Non-metallic Filter in Diagnostic Radiography": John J. Douglas, M.D., LaGrange, Georgia.

"Examination of Colon and Rectum": American Cancer Society, Georgia Division, Atlanta, Georgia.

"A Patient Propulsion Procedure for Aorto-Arteriography": Russell Wigh, M.D.; William F. Lindsey, M.D.; Jack Morgan, B.S., and Winford H. Pool, Jr., M.D., Augusta, Georgia.

"Hemobilia": Harold S. Engler, M.D.; Alberto A. Zavaleta, M.D., and William H. Moretz, M.D., Augusta, Georgia.

"Services for Crippled Children": Crippled Children's Service, Georgia Department of Public Health, Atlanta, Georgia.

"Trichomonas Vaginalis": Wesley L. Southerland, M.D.; C. I. Bryans, Jr., M.D.; D. F. Mullins, Jr., M.D., and Walter Romine, Augusta, Georgia.

"The Papanicolaou Smear—A Screening Test for Cancer": D. F. Mullins, Jr., M.D.; C. I. Bryans, Jr., M.D.; F. P. Zuspan, M.D., and W. L. Southerland, M.D., Augusta, Georgia.

Information

"Removal of Pitted Scars with Surgical Dermabrasion": W. L. Dobes, M.D., Atlanta, Georgia.

Commercial Exhibits

Approximately 61 commercial exhibits will be displayed in exhibit booths adjacent to the Main Meeting Room. These exhibits will give up-to-date information on the latest products and services available to the medical profession.

It is *extremely* important that you visit each of these exhibits and register with the exhibitor. Your cooperation is *requested* since these displays are designed and shown specifically for your benefit. The exhibitor plays an extremely important role in making this Annual Session possible and the Association Commercial Exhibit Committee strongly urges your participation in this area of Association activity. A list of these exhibits is given as follows:

Booth

Number	Name of Company
1	Parke Davis & Company, Atlanta, Georgia
2	Davies, Rose & Company, Ltd., Boston Massachusetts
6	Carnation Company, Los Angeles, California
8	Breon Laboratories, Atlanta, Georgia
9	A. H. Robins, Co., Inc., Richmond Virginia
10	Merck Sharp & Dohme Co., Inc., Philadelphia, Pennsylvania
11	Mead Johnson & Company, Evansville, Indiana
12	Lederle Laboratories, Pearl River, New York
13	American Sterilizer Company, Erie, Pennsylvania
14	The Lanier Company, Atlanta, Georgia
15	Medical Supply Company, Jacksonville, Florida
17	Knoll Pharmaceutical Co., Orange, New Jersey
18	Desitin Chemical Company, Providence 4, Rhode Island
19	Wampole Laboratories, Stamford, Connecticut
20	Brooks-Burke Surgical Supply, Atlanta, Georgia
23	Pfizer Laboratories, Brooklyn, New York
24	A. S. Aloe Company, Chamblee, Georgia
25	Schering Corporation, Union, New Jersey
26	Ross Laboratories, Columbus, Ohio
28	Ciba Pharmaceutical Products, Inc., Summit, New Jersey
29	Royal Crown Cola Company, Columbus, Georgia
30	J. B. Roerig and Company, New York, New York
32	Julius Schmid, Inc., New York, New York
33	Warren Teed, Columbus, Ohio
34	Charles C. Haskell & Co. Richmond, Virginia
38	Wm. P. Poythress & Co., Richmond, Virginia
39	Estes Surgical Supply Co., Atlanta, Georgia
40	Eaton Labs, Norwich, New York
41	American Surgical Supply Co., Atlanta, Georgia
42	DOHO Chemical Corp., New York, New York
45	Sandoz Chemical Works, Inc., Hanover, New Jersey
46	The Coca-Cola Co., Atlanta, Georgia
47	G. D. Searle & Company, Chicago 80, Illinois
48	Abbott Laboratories, North Chicago, Illinois
49	The Borden Company, New York, New York
51	U. S. Vitamin & Pharm. Corp., New York, New York
52	Vanpelt and Brown, Inc., Richmond, Virginia
53	The S. E. Massengill Company, Bristol, Tennessee
54	Westwood Pharmaceuticals, Buffalo, New York
55	Eli Lilly and Company, Indianapolis, Indiana
56	Warner Chilcott Laboratories, Morris Plains, New Jersey
59	The Purdue Frederick Company, New York, New York
60	Winthrop Laboratories, New York, New York
61	J. A. Major Company, Atlanta, Georgia

Fifty-Year Members

The following list contains the names of all the members of the Medical Association of Georgia who as of the year, 1961, have practiced medicine for 50 years. It does not record the names of physicians who have already received gold membership cards. This is the class of 1960, as follows:

Malcolm W. Anderson	Social Circle
Frank Bird	Lark Park
Montague L. Boyd	Atlanta
Thomas H. Brabson	Cornelia
Allen H. Bunce	Atlanta

Information

William L. Cousins	Atlanta
Leo P. Daly	Atlanta
Bruce Jackson	Newnan (Deceased)
Andrew J. Jones	Jacksonville
Spencer A. Kirkland	Atlanta (Deceased)
George H. Lang	Savannah
Samuel J. Lewis	Augusta
Dick R. Longino	Atlanta
James C. McDougall	Atlanta
Ruben S. O'Neal	LaGrange
James A. Redfearn	Albany
Joseph R. Robertson	Augusta
Ernest B. Saye	Milledgeville
Thomas H. Smith	Valdosta
Claude V. Vansant, Sr.	Douglasville
Ralph C. Williams	Atlanta

Golf

A tournament will be arranged at the Druid Hills Country Club on Tuesday, May 9. A low net score prize will be awarded. Tournament rounds can be started from 10:00 A.M. on this date. A member of the arrangements committee will be present to regis-

ter players and arrange foursomes. No prior reservations are necessary.

The following country clubs have authorized play on Sunday, May 7; Monday, May 8, and Tuesday, May 9: (1) Capital City; (2) Peachtree Golf Club; (3) East Lake, and (4) Standard Town and Country. However, it is *mandatory* that the local arrangements committee know the name of the members desiring to play on these courses, the exact date, and the approximate time of play. *These rounds cannot be arranged if the local arrangements committee is not notified before 6:00 P.M. on Saturday, May 6.* Dr. William Bennett will act as local coordinator for these golf dates. A Calloway score prize will be awarded for the best score turned in on Sunday, Monday, or Tuesday. The Druid Hills tournament rounds on Tuesday will be included in this tournament.

Please notify Dr. William Bennett, Suite 409, Baptist Professional Building, 340 Boulevard, N.E., Atlanta 12, Georgia, if you desire to make reservations at the Capital City Club, Peachtree Golf Club, East Lake Country Club, or Standard Town and Country Club, prior to May 6, 6:00 P.M.

VOTING RULES

Bylaws, Chapter V, Election of Officers

SECTION 3, METHOD. The President shall appoint a committee of not less than three Tellers immediately after the close of nominations, who shall have charge of the election. The Secretary shall have prepared in advance an official ballot and an official ballot box, which shall be kept in the custody of the Tellers Committee. One ballot only shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in the locked ballot box.

The candidates for office receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select by secret ballot the officer from the two candidates having the highest number of votes.

SECTION 4. TIME. Voting shall take place during the hours of the scientific program up to the beginning of the last meeting on the last day of the Annual Session. At that time the Committee of Tellers shall count the ballots and report their findings to the members.

GUEST SPEAKERS

LEONARD W. LARSON M.D.
Bismarck, N. D.



Leonard W. Larson, M.D., one of the country's leading pathologists, is the president-elect of the American Medical Association.

Holder of an Alumni Outstanding Achievement award, Dr. Larson was graduated magna cum laude from the University of Minnesota Medical School, having received his bachelor of science degree and his college preparatory education at St. Olaf Academy, Northfield, Minn.

Besides serving as pathologist for Bismarck's two 200-bed hospitals, Dr. Larson with four other partners operates the 30-doctor, 110-employee Quain and Ramstad Clinic, which serves an estimated population area of 250,000.

For his contributions to the science of cancer control, Dr. Larson received a Gold Medal in 1953 from the American Cancer Society, having served on the society's board of directors since 1945, including a term as national vice president.

He received a Certificate of Highest Merit from the American Society of Clinical Pathologists, after serving as that organization's president, 1939-1940, and as chairman of its executive committee.

Dr. Larson was elected chairman of the American Medical Association's Board of Trustees in 1958, and has served on the Board since 1950.

As Chairman of the A.M.A. Correlating Committee on Lay-Sponsored Health Plans, he was instrumental in formulating the "Twenty Principles" covering the relationship between the medical profession and the plans. He was subsequently appointed chairman of the Commission on Medical Care Plans. Other A.M.A. responsibilities have included chairmanship of the Trustees' Committee on Socio-Economic Problems of the Profession, and Chairmanship of the Committee on Blood. He is one of several who organized the Joint Blood Council, serving for four years as president of this group.

Dr. Larson has been a United States delegate to the World Medical Association for the past four years and was a member of the National Advisory Council for the White House Conference on Aging,

held in January 1961. He was secretary of the North Dakota State Medical Association for several years and served as its president in 1950-1951.

Dr. Larson has written a number of published works since 1930, including scientific articles on laboratory medicine, with particular emphasis on tumor diagnosis and treatment.

On Sunday, May 7, at 5:45 P.M., Dr. Larson will address the MAG on "Your A.M.A.—1961." A short summary follows:

The A.M.A. is accelerating its efforts in many fields of public interest and medical interest. Significant projects are underway to reduce needless accidental deaths, to prevent crippling disease, and to improve the health standards of Americans of all ages.

For member-physicians and prospective physicians, your A.M.A. has launched various programs in scientific, socio-economic, medical, and legislative areas to help solve immediate and long-range problems confronting individual practitioners and the profession as a whole.

RAY O. NOOJIN M.D.
Birmingham, Ala.



Ray O. Noojin, M.D., is Professor and Chairman of the Dermatology Department of the University of Alabama Medical Center in Birmingham. He will present a paper, "The Precancerous Dermatoses," at 9:30 A.M. on Monday, May 8, and the following is a short precis of that paper:

The premalignant or precancerous dermatoses include: (1) senile keratosis, (2) leukoplakia, (3) cutaneous lesions resulting from exposure to certain tars, roentgen, or radium therapy, (4) Bowen's disease, and (5) keratosis resulting from ingestion of arsenic. Actually this group may be considered as intraepidermic carcinoma. Although they may remain clinically benign for years, eventually 20 per cent of these will invade the dermis as malignant tumors.

Each of these will be discussed from the standpoint of diagnosis, medical significance, and treatment.

Dr. Noojin received his M.D. degree from the University of Chicago and did postgraduate training in medicine and dermatology at Duke University.

He is past president of the Southeastern Dermatological Association and a past chairman of the dermatologic section of the Southern Medical Association.



CHARLES R. ALLEN M.D.
Galveston, Texas

CHARLES R. ALLEN, M.D., will present a paper entitled "The Toxicity of Local Anesthetic Drugs" at 3:00 P.M., Sunday, May 7. The following is a short precis of that paper:

Although potency and duration of action are important considerations in the evaluation of a local anesthetic drug, the right to general acceptance for clinical usage will be decided by its relative toxicity. The principal factors which determine toxicity depend upon (1) the rate of diffusion into the tissues, (2) the rate of absorption into the blood stream, (3) the rate of inactivation, (4) the inherent toxicity of the drug, and (5) the degree of susceptibility of the individual to the drug. Reactions to local anesthetics may be local, systemic, or true allergy phenomena. The physician who uses regional anesthesia should be ever alert to the recognition of toxic symptoms and to the principles of prevention and treatment of these reactions should they occur.

It is virtually impossible to correlate the vast accumulation of data from various laboratories concerning potency and toxicity of drugs of this type because of the diversity of experimental methods and animals employed to obtain the data. An objective method has now been established for evaluating and comparing the toxic effects of various local anesthetic drugs on tissue cultures of human respiratory epithelium. A movie illustrating the technique and studies with phase-contrast photomicrography will be used to compare the toxicity of Novocaine,[®] Xylocaine,[®] cocaine, Pontocaine,[®] and Nupercaine.[®]

Dr. Allen will also present another paper at 9:20 A.M. on Monday, May 8, entitled "Muscle Relaxants for Abdominal Procedures," of which a short summary follows:

Prior to 1940, curare was a medical curiosity. Good muscle relaxation was often a challenge to the experienced anesthetist who wished to produce satisfactory working conditions for the surgeon without also producing cardiovascular depression with profound anesthesia. Because of this challenge the effects of physiological positioning, plasma carbon dioxide variations, tissue hypoxia, and the inherent muscle relaxing properties of the various regional and general anesthetic drugs received careful laboratory and clinical evaluation. From these studies it was realized that with the pa-

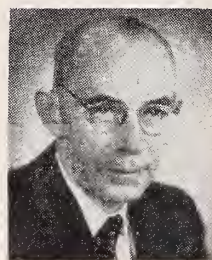
tient in physiologically proper positions on the operating table, with the maintenance of normal $p\text{CO}_2$ and blood O_2 tensions and with the selection of proper anesthetic agents, adequate muscle relaxation could usually be maintained without long periods of deep anesthesia. The advent of d-tubocurarine and succinylcholine then made it possible to produce excellent relaxation by adding only small amounts of these specific muscle relaxants.

Unfortunately, physiological considerations in anesthetic management may be ignored, but profound muscle relaxation still be obtained if larger amounts of d-tubocurarine or succinylcholine are administered. Results of such management are reflected in many of the cardiovascular crises in surgery as well as periods of prolonged respiratory and circulatory depression in the recovery room. With the continual increase in the number of elderly and "poor-risk" patients now being presented for extensive abdominal procedures, it is desirable that we review our techniques of management, reaffirm the need for adherence to physiological principles, and employ muscle relaxants whenever indicated but then, only to the extent that they are indicated.

Dr. Allen is Professor and Chairman, Department of Anesthesiology, University of Texas Medical Branch Hospitals in Galveston.

A native of Bowling Green, Ky., he received his B.S. and M.A. degrees from Western Kentucky State Teachers College, Ph.D. degree from the University of Wisconsin, and M.D. from the University of Wisconsin Medical School.

Dr. Allen is a Diplomate, American Board of Anesthesiology; Fellow, American College of Anesthesiologists, and is presently serving on the Board of Governors for the latter. His present consultancies include the U.S. Public Health Service Hospital, Galveston; Brooke Army Hospital, Fort Sam Houston, and the U. S. Air Force Hospital, Lackland Air Force Base, Texas.



TINSLEY R. HARRISON M.D.
Birmingham, Ala.

TINSLEY R. HARRISON, M.D., will deliver the Abner W. Calhoun Memorial Lectureship at 12:00 noon, Tuesday, May 9. "Birthdays and Heart Disease" is the title of the lecture and a brief precis follows:

Clinical experience teaches us that the old heart will frequently fail under the influence of burdens which are readily tolerated by the young heart. The widely accepted explanation for this is that of "arteriosclerotic heart disease" which implies

that disease of the smaller coronary branches produces ischemia which is responsible for the impairment of contractility. However, there are studies of the perfusability of the coronary system which fails to demonstrate ischemia in such hearts. In a considerable percentage of elderly patients dying of congestive failure no explanation is found at autopsy.

The lecture will deal with the evidence pro and con of the concept of "arteriosclerotic heart disease" versus that of presbycardia (senile heart disease). Certain recent studies which indicate impairment of contractile force in the old normal as compared to the young normal human heart will also be offered.

Born in Talladega, Ala., and brought up in Birmingham, Dr. Harrison received his A.B. degree from the University of Michigan and his M.D. degree from Johns Hopkins University. His internship was done at Peter Bent Brigham Hospital and took his residency at Boston, Baltimore, and Nashville. He left Nashville as Associate Professor of Medicine to accept the professorship at Bowman Gray School of Medicine, Winston Salem, N. C. in 1941 and in 1944 he went to Dallas as the Professor of Medicine at Southwestern Medical College. Six years later, he accepted the professorship of medicine at the Medical College of Alabama, in Birmingham, where he has remained.

Dr. Harrison is a member of the Association of American Physicians, American Medical Association, American College of Physicians, American Heart Association, and others.

MILTON L. McCALL M.D.
Pittsburgh, Pa.



MILTON L. McCALL, M.D., is Professor and Chairman of the Department of Obstetrics and Gynecology, University of Pittsburgh School of Medicine, and Medical Director and Chief of Staff of the Elizabeth Steel Magee Hospital in Pittsburgh.

Dr. McCall will present a paper, "The Radical Vaginal Operation for Carcinoma of the Cervix in Modern Gynecologic Practice" at 9:30 A.M., Monday, May 8. The following is a precis of that paper:

The ideal therapy for cancer of the cervix is still being searched for. In spite of newer aspects of chemotherapy, radiation and surgery are the only reliable types of therapy today. Each method, however, gives rise to serious complications. Radiation often causes bowel and urinary tract com-

plications which are insidious in their development over a period of months and years. Radical abdominal surgery produces the most immediate spectacular injuries and the high incidence of ureterovaginal fistula is especially depressing.

Whenever surgery for cervical cancer is mentioned, the radical abdominal operation is the procedure which immediately comes to mind, inasmuch as the radical vaginal operation has not been adequately evaluated in recent times. With the point in view of re-evaluating the Schauta-Amreich operation in the light of our present surgical advantages, the author has performed this operation on well over 100 cases of women with cancer of the cervix, Stages I to IIA, International Classification.

This procedure inflicts less stress upon the patient than the radical abdominal procedure and, therefore, may be extended to a larger group of older, obese, or medically debilitated patients. The greatest amount of parametrial and paravaginal tissues may be removed with greater ease than in most abdominal operations. The pelvic lymph nodes may be efficiently removed extraperitoneally at the time of vaginal operation or at a second stage. The primary mortality is as low as with other types of therapy for cervical cancer, and the incidence of fistula is much less than with the radical abdominal approach and compares favorably with irradiation in this respect.

It is felt that the Schauta-Amreich radical vaginal operation should be utilized more than ever before in medical centers whose aim it should be to offer the patient with cervical cancer every modality of therapy which could be to her individual advantage.

"Experiences in the Management of Severe Toxemias of Pregnancy" will also be presented by Dr. McCall on Monday, May 8 at 3:00 P.M. A short summary of his paper follows:

The fundamental principles in regard to the changes in normal function of the body brought about by toxemia of pregnancy will be mentioned, as well as discussion of the modern treatment of this disease, especially the use of vasodilator drugs.

This disease is still one of the real obstetrical problems. The hypertensive complications are especially significant. The speaker will review some of the effects of toxemia upon body function and discuss the modes of therapy which have been helpful both medically and obstetrically.

Dr. McCall received his degrees at the Indiana University School of Medicine and postgraduate training in obstetrics and gynecology in Philadelphia.

Although he was in private practice in obstetrics and gynecology for many years, Dr. McCall has always held faculty appointments in the teaching of his specialty.

Before coming to Pittsburgh in July, 1959, he was professor and chairman of the Department of Obstetrics and Gynecology at Louisiana State University School of Medicine, New Orleans and Senior Visiting Surgeon, Charity Hospital.

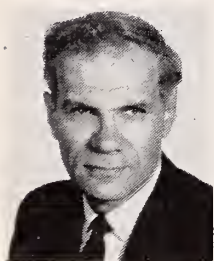
Many papers have been published by Dr. McCall on obstetrics and gynecology, including toxemia of pregnancy, pelvic malignancy, surgical techniques, and diagnostic methods.



JAMES J. GRIFFITTS M.D.
Miami, Fla.

JAMES J. GRIFFITTS, M.D., will present a paper at 3:00 P.M., Monday, May 8, concerning the nature of antibodies encountered in patients' serums at the time of the crossmatch. He will also present another paper Tuesday, May 9, at 11:00 A.M., which will deal briefly with the problems in complete compatibility of blood.

Dr. Griffitts is a graduate of the University of Virginia and entered the United States Public Health Service in 1939. He is president of Dade Reagents, Inc.; a past president of the American Association of Blood Banks; past president of the Florida Association of Blood Banks, and a Fellow, A.S.C.P.



RALPH D. RABINOVITCH M.D.
Northville, Mich.

RALPH D. RABINOVITCH, M.D., is Director of Hawthorn Center, a newly established in-patient and out-patient facility for treatment, training, and research in child psychiatry under the Department of Mental Health, State of Michigan.

On Sunday, May 7, at 3:10 P.M., Dr. Rabinovitch will discuss "Distortions of Development due to Psychological Stress," a summary of which follows:

An outline of personality development is presented with discussion of specific effects of deprivations or distortions in relationships in the infancy period, pre-school period, elementary school years, and adolescence. Reference is made to pertinent research studies involving both direct observation and retrospective evaluation. The major focus of the discussion is application of these findings to pediatric and general practice.

"Reading Retardation—A Psychiatric, Neurological, and Educational Approach" will also be presented by Dr. Rabinovitch on Monday, May 8, at 9:00 A.M. A short precis of his paper follows:

Reading retardation is viewed as a common and often neglected symptom in childhood and adolescence. Etiology is considered under two

broad headings: primary retardation (dyslexia) and secondary retardation (emotional blocking, etc). Pertinent research studies are reviewed and rehabilitation techniques discussed with special application to public school programs.

Dr. Rabinovitch received his M.D. degree from McGill University, Montreal, and psychiatric training at Toronto University and New York University.

From 1949 to 1956, he was Chief of Children's Service, University of Michigan and Associate of Psychiatry. In 1956 he resigned from the University of Michigan to accept his present position.

Research publications include studies on foster home placement and adoption, juvenile delinquency, childhood schizophrenia, children's graphic art, reading retardation, and techniques of in-patient treatment of emotionally disturbed children.



MILTON HELPERN M.D.
New York, N. Y.

MILTON HELPERN, M.D., Chief Medical Examiner of the City of New York, is Professor and Chairman, Department of Forensic Medicine, New York University Postgraduate Medical School and Assistant Professor of Clinical Medicine and Lecturer in Pathology and Legal Medicine, Cornell University Medical School.

Dr. Helpern will present a paper at 3:00 P.M., Wednesday, May 10, entitled "Investigation and Examination of Disinterred Bodies" during the Medical-Legal Workshop at Grady Memorial Hospital Auditorium.

Having received his B.S. degree from the College of the City of New York, Dr. Helpern, received his M.D. degree from Cornell University Medical College, and is certified by the American Board of Pathology in Pathologic Anatomy and Forensic Pathology.

Having served as president and secretary of the New York Pathological Society, Dr. Helpern is also a Fellow, College of American Pathologist, American Society of Clinical Pathologists, and New York Academy of Medicine, and is a member of the American Association of Pathologists and Bacteriologists and the American Academy of Forensic Sciences.

Dr. Helpern has made many contributions to the literature.

MARK M. RAVITCH M.D.
New York, N. Y.



MARK M. RAVITCH, M.D., will present a paper entitled "Current Attitudes on the Treatment of Peptic Ulcer" at 11:00 A.M., Monday, May 8. Also on Monday, May 8, at 2:30 P.M., he will discuss "Techniques of Ventral Hernia Repair."

Dr. Ravitch received an A.B. degree from the University of Oklahoma and his M.D. degree from Johns Hopkins University School of Medicine, where he also received postgraduate training.

As a Fellow, New York Academy of Medicine, Dr. Ravitch is also Surgeon in Chief, Baltimore City Hospitals; Associate Professor of Surgery, Johns Hopkins University; a member of the American Board of Surgery, Board of Thoracic Surgery, American Surgical Association, American Association for Thoracic Surgery, Society of University Surgeons, The Southern Surgical Association, American College of Surgeons, and the New York Academy of Medicine. He is also on the editorial board of *Quarterly Review of Surgery*, associate editor of *Surgery* (Pediatrics), and editor of *Pediatric Surgery Monographs*.

SOL KATZ M.D.
Washington, D.C.



SOL KATZ, M.D., Chief, Medical Service, Veterans Administration Hospital; Associate Professor of Medicine, Georgetown University School of Medicine, and Professional Lecturer in Medicine, George Washington School of Medicine in Washington, will present a paper entitled, "Noncardiac Vascular Disorders of the Thorax" at 10:30 A.M., Monday, May 8. The following is a short precis of Dr. Katz's paper:

There are numerous congenital and acquired disorders of the pulmonary vessels, thoracic systemic veins, and thoracic arteries. These present clinical and roentgen features which may suggest

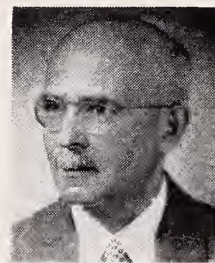
the diagnosis. Contrast visualization provides a simple method for the precise identification of many of them.

At 2:30 P.M., Monday, May 8, Dr. Katz will also present a paper "Patterns of Histoplasmosis;" a summary follows:

The textbook concept of histoplasmosis makes it a rare and serious disease. In reality it is common—certainly the most common systemic fungus infection. It is often a benign disorder with multiple clinical and roentgen patterns which may simulate other more serious entities.

The many roentgen patterns and guises of histoplasmosis will be demonstrated and methods of diagnosis discussed.

Dr. Katz is consultant in Chest Diseases at Georgetown University Hospital, Newton Baker Veterans Hospital in Martinsburg, W. Va., Clinical Center, National Institute of Health, Children's Hospital, and District of Columbia General Hospital. He is Associate Editor of *GP*; Chairman, Fellowship Board, American Thoracic Society; member of the Committee on Medical Education, American Trudeau Society, and a member of the Chemotherapy Committee, American College of Chest Physicians.



ANDREW L. BANYAI M.D.
Chicago, Ill.

ANDREW L. BANYAI, M.D., F.A.C.P., F.C.C.P., will present a paper entitled "Pathogenesis and Treatment of Pulmonary Emphysema" at 4:00 P.M., Monday, May 8 and the following is a short summary of his paper:

In recent years, there has been a substantial increase in the incidence of emphysema. This fact demands proportionate attention on the part of the practicing physician. The increase is attributable to several etiologic factors which require elucidation. It is hoped that by clarifying the pathogenesis of this disease one may facilitate the use of appropriate measures for its prevention and effective treatment.

Emphysema entails the possibility of serious respiratory insufficiency. Absenteeism and invalidism resulting from it should be looked upon as challenging problems. Moreover, its potentiality as a disabling condition is enhanced by pathologic changes which render the lung highly susceptible to superimposed infections. The more severe the emphysema, the less tolerant the patient to infection. For instance, bronchopneumonia may easily lead to fatal termination because of acute lung failure. Sclerosis of the bronchial arteries,

branches of the lesser circulation, and cor pulmonale are sequels which should be considered in accordance with their influence upon cardiovascular competence. Several other complications of emphysema which require treatment will be discussed.

Even though emphysema is a serious disease, there is no justification for a negative or nihilistic attitude concerning its management.

Dr. Banyai is Clinical Professor of Medicine, Emeritus, Marquette University School of Medicine; past president of the American College of Chest Physicians; member of the editorial board of *Diseases of the Chest*, *Occupational Therapy and Rehabilitation*, and *Chest Diseases Section of Excerpta Medica*.

As the author, editor and co-author, and contributing author of several textbooks, Dr. Banyai is also the author of over 120 articles published in medical journals.



JACK LAPIDES M.D.
Ann Arbor, Mich.

JACK LAPIDES, M.D., Associate Professor of Surgery, Department of Surgery, University of Michigan Medical Center; Chief, Section of Urology, Wayne County General Hospital, and Chief, Section of Urology, Ann Arbor Veterans Administration Hospital, will present a paper entitled, "Physiology of the Urinary Sphincter and Its Relationship to Operations for Stress Incontinence," at 10:30 A.M., Monday, May 8. Dr. Lapides' paper is presented below in summary form.

Urinary incontinence has been a poorly understood entity for many years because of insufficient knowledge concerning the normal process of micturition. In recent years experimental work has elucidated the structure and function of the normal bladder and its sphincter sufficiently to permit research into some of the abnormalities of urination.

The bladder and proximal three-fourths of the urethra in the female are one integrated structure embryologically, anatomically, and physiologically. Requisites for physiological micturition and continence are (a) intact central nervous system and peripheral nerve supply to the bladder, urethra, and pelvic striated muscles; (b) normal bladder and urethra, and (c) a urethral length of at least 3.0 cm.

Most instances of stress incontinence in the female are due to a telescoping or shortening of the urethra when the erect position is assumed.

Appropriate therapy for these individuals is fixation and elongation of the urethra anteriorly. In some patients urethral length is within normal limits, but damage to the urethral wall has resulted in a functional decrease in urethral length. Logical treatment for these people involves excision of the damaged portion of the urethra and reapproximation of the normal edges of the urethra.

Dr. Lapides will also present a paper entitled "Use of Renal Function Tests in Surgical Practice" on Monday, May 8 at 4:00 P.M. and the following is a short summary:

Selection of a patient for surgery and the type of operative procedure employed depend to a great extent upon the condition of the patient's homeostatic organs. All patients being considered for surgery should have their renal function evaluated before operation. From a clinical viewpoint, this can be accomplished most efficiently with the determination of the 15-minute PSP test and the serum creatinine level. The BUN and NPN are poor excuses for baseline renal function tests and should be used only for serial follow-up evaluation of renal function after PSP and serum creatinine have been obtained.



RICHARD FORD M.D.
Boston, Mass.

RICHARD FORD, M.D., Chief Medical Examiner of Boston, will take part in the Medical-Legal Workshop to be held at Grady Memorial Hospital Auditorium with a discussion of "Hidden Causes of Death" at 1:00 P.M., Wednesday, May 10.

Born at Cambridge, Mass., Dr. Ford received his A.B. and M.D. degrees from Harvard University. He did postgraduate work at Peter Bent Brigham Hospital, Boston City Hospital, and Harvard.

Dr. Ford is Assistant Professor of Legal Medicine at Harvard; pathologist to the State Police, Commonwealth of Massachusetts; consultant in pathology at the Peter Bent Brigham Hospital, and consultant in forensic pathology at the Massachusetts General Hospital.

Having been certified in Forensic Pathology by the American Board of Pathology, Dr. Ford was awarded the Legion of Merit. He is a member of the American Medical Association, American Association of Pathologists and Bacteriologists, American Academy of Forensic Sciences; Fellow, College of American Pathologists, and consultant to the Armed Forces Institute of Pathology.

MR. GEORGE E. HALL

Chicago, Ill.



MR. GEORGE E. HALL, will present a paper entitled "Some Medicolegal Contributions of the General Practitioner" at 9:50 A.M., Tuesday, May 9. A short precis follows:

Specialist practitioners are by no means the only physicians who are called upon to appear in court as medical witnesses. General practitioners make many, and important, contributions to the field of legal medicine. This is particularly true, of course, in rural areas but it will become more true all the time in all areas in particular types of cases.

The general practitioner already plays an important part in situations relating to adoption, will contests, workman's compensation, and personal injury. He will become an increasingly major factor in the treatment of the mentally ill because of the growing emphasis on voluntary commitments and the growing realization that the staffs of psychiatric hospitals should be open to the patients of general practitioners and not just psychiatrists.

One of the greatest contributions of the general practitioner is in the field of educating the public to the value of a more adequate utilization of science in the administration of justice.

Also on Wednesday, May 10, at 4:30 P.M. during the Medical-Legal Workshop to be held at the Grady Memorial Hospital Auditorium, Mr. Hall will discuss "Forensic Medicine and the A.M.A." A summary of Mr. Hall's paper follows:

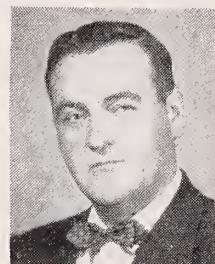
The American Medical Association has had a long and consistent history of interest in forensic medicine. At its second meeting in 1849, it created a Committee on Forensic Medicine. Four years later it took its first steps in the field of state legislation by recognizing the need for adequate state medical licensing statutes. In 1855 the Association exhibited its first interest in the inadequacies of the coroner system as it was operated throughout the country, and reported that the person appointed or elected to the position of coroner should by all means be a competent and respectable doctor of medicine.

During the intervening years, until 1923, the Association took an active interest in such varied problems as criminal abortion, expert medical testimony, anti-vivisection activities, courses in medical jurisprudence, malpractice, narcotic acts, and model state laws relating to the prevention of blindness. In 1923 the Association created the Bureau of Legal Medicine for the purpose, among other things, of studying the malpractice problem and all other legal matters of concern to the science of medicine and to the medical profession. The activities of the Bureau were assumed by the Law Division in 1952 and are now being pursued on a cooperative basis by the Law Department and the Department of Legal Medicine.

In 1950 the Board of Trustees created the Committee on Medicolegal Problems composed of specially appointed members of the Association. With the assistance of the staff of the Department of Legal Medicine, this committee is presently preparing studies and reports on medicolegal education in medical schools, chemical tests for intoxication, blood tests in disputed paternity cases, blood transfusions, medical examiner systems, commitment and sterilization laws, professional liability, etc.

A graduate of Lawrence College, Mr. Hall received his J.D. degree from Chicago-Kent College of Law and was licensed to practice law in Illinois in 1935. He joined the staff of A.M.A. in 1940, where he has served as executive secretary of the Committee on Medicolegal Problems. His present title is director of the Department of Legal Medicine.

Mr. Hall is a member of the Illinois and American Bar Associations and the American Academy of Forensic Sciences; is on the editorial board in Forensic Jurisprudence of *Journal of Forensic Sciences*, and is editor of "The Doctor and the Law," a monthly newsletter for physicians.



GEOFFREY T. MANN M.D.

Richmond, Va.

GEOFFREY T. MANN, M.D., LL. B., Chief Medical Examiner of Virginia, will discuss "Traumatic Injuries: Cutting, Stabbing, and Gunshot" at 9:00 A.M., Wednesday, May 10, at the Medical-Legal Workshop, Grady Memorial Hospital Auditorium. Briefly, his discussion will be as follows:

Cuts and stabs are penetrating injuries caused by piercing and cutting instruments. Such wounds frequently display characteristic features of the object responsible for the injury; therefore, they are of important medicolegal interest. Cutting and stabbing wounds will be discussed from the viewpoint of classification and incidence emphasizing that cutting and stab wounds account for a large number of suicides and homicides throughout the country; from the viewpoint of medicolegal problems involved; objectives in the examination, and equipment recommended. The characteristics of suicidal and homicidal cuts will be given attention, and the proper method of describing and recording the wounds will be emphasized. Stab wounds of various portions of the body will be discussed, and their effect on volitional action following the

receipt of the fatal injury will be emphasized. Something will be said about giving evidence in cases of stabbing and cutting with the view to its proper presentation to a jury.

Under deaths due to gunshot wounds, the information required in all cases of fatal injury by firearms will be discussed. It will be pointed out that from a legal standpoint scientific evidence carries a greater potential value in fatal injury by firearms than any other type of violent or natural death, this being particularly true of unwitnessed shootings or those in which witnesses to the shooting are found to be unreliable. Invariably, the information needed can be drawn from a careful examination of the death scene and the body of the decedent. The principle sources of evidence in fatal injury by firearms will be gone into. The appearance and pathology of gunshot wounds of exit and entrance will be emphasized. Some elementary ballistics will be discussed and there will be a consideration of the differential diagnosis of accident, suicide, and homicide in gunshot wounds.

Dr. Mann received his B.A. and LL.B. degrees from the University of Saskatchewan, his M.D. degree from the University of Manitoba, and has been certified by the American Board of Pathology.

His present positions include Professor and Head of the Department of Legal Medicine, Chairman, Department of Law, School of Hospital Administration, and Professor, Department of Pathology, Division of Forensic Pathology, Medical College of Virginia; Lecturer in Legal Medicine, University of Virginia, Charlottesville; Consultant, Federal Aviation Agency, and Consultant, Armed Forces Institute of Pathology.

As president of the Virginia Society of Pathologists, Dr. Mann is also a member of the American Medical Association, American Academy of Forensic Sciences, Canadian Medical Association, Canadian Bar, College of American Pathologists, and a Fellow of the Royal Society of Tropical Medicine and Hygiene.

ROBERT E. WISE M.D.
Boston, Mass.



ROBERT E. WISE, M.D., a staff member at the Lahey Clinic and radiologist at the New England Baptist Hospital, will speak on "Preparation of the Colon for Barium-Air Contrast Examina-

tion" at 2:30 P.M., Sunday, May 7. A short summary of this paper follows:

Recognizing the inadequacy of cathartic preparation of the colon for barium-air contrast examination, this has been supplemented by a preliminary cleansing enema containing traces of barium and a phenolphthalein derivative. The method permits, in many instances, excellent air contrast enema films in a colon containing residual barium from previous upper gastrointestinal studies.

On Sunday, May 7, at 3:30 P.M., Dr. Wise will present a paper, "Intra-osseous Venography," the following being a precis of that paper:

Intra-osseous venography offers a unique method of evaluation of the veins of the lower extremities when conventional percutaneous venography fails or is impractical. Its greatest field of usefulness has been in evaluation of pelvic malignancy prior to radiation therapy and for post radiation follow-up studies. Additional applications have been the study of the edematous lower extremity and study of the post-mastectomy swollen arm.

A simple technique has been devised. A Kirschner wire is drilled through the cortex of the bone. A special needle, passed through this opening, serves for the injection of contrast medium.

The unusually rich venous drainage of bone permits rapid filling of both the superficial and deep systems of the extremities without the use of a tourniquet, thus eliminating a potential source of error.

Obstructive phenomena in relation to various disease entities will be presented.

Dr. Wise will present another paper at 9:50 A.M., Monday, May 8. The following is a summary of the paper, "Intravenous Cholangiography—A Surgical Evaluation":

Since the introduction of intravenous cholangiography in 1954, the procedure has become a well accepted one in the armamentarium of the diagnostic radiologist and has proven a boon to bile duct surgery. Statistical data based upon 466 surgical procedures performed upon patients in whom bile duct visualization had previously been obtained will be presented. Diagnostic accuracy will be evaluated in relation to surgical findings. Interpretation and pitfalls will be stressed. While useful for examination of the gall bladder, the most valuable application has been the examination of the common bile duct in the post-cholecystectomy patient in the detection of calculi, stenosis, stricture, and other obstructive disease.

On Tuesday, May 9 at 2:30 P.M., Dr. Wise will also discuss "Radiological Diagnosis of Polyps of the Colon;" the following is a short summary:

The discussion will include an evaluation and presentation of the various techniques of detection of polyps of the colon including routine barium enema, high kilovoltage technique, and air contrast enema.

Dr. Wise is a graduate of the medical school at the University of Maryland and received his radiological training at the Cleveland Clinic Foundation, following which he was appointed to the staff of the same institution.

He is a member of the American Medical Asso-

ciation, the Radiological Society of North America, the American Roentgen Ray Society, the Eastern Radiological Society, and is a Fellow in the American College of Radiology.

As the author of numerous scientific papers, at the present time Dr. Wise is preparing a monograph on the subject of cholangiography.

BURIS R. BOSHELL M.D.
Birmingham, Ala.



BURIS R. BOSHELL, M.D., is Assistant Professor of Medicine, Medical College of Alabama.

A native of Marion County, Ala., Dr. Boshell received a B.S. degree and two years of veterinary medicine at the Alabama Polytechnic Institute, attended the Medical College of Alabama, and received his M.D. degree from Harvard Medical School. His postgraduate training was received at Peter Bent Brigham Hospital in Boston.

Dr. Boshell is a member of the American Federation for Clinical Research, Endocrine Society, American Diabetes Association, New England Dia-

betes Association, and the Alabama Society of Medical History.

Dr. Boshell will present a paper entitled "Ten Cases of Insulin Resistant Diabetes—Clinical and Experimental Study" at 11:30 A.M., Monday, May 8. A summary of Dr. Boshell's paper follows:

Six insulin resistant diabetic patients have been studied for at least six months and three others for shorter periods. There are seven females and two males in the group. Two of the patients have pituitary tumors and two have been in severe acidosis. Baseline measurements of serum insulin-like activity, insulin binding capacity, insulin tolerance tests, serum electrophoretic patterns, insulin disappearance curves, thyroid function tests, adrenal and pituitary function tests have been performed.

Steroid, tolbutamide, and nitrogen mustard therapy have been evaluated. Three of the patients have responded to tolbutamide. Baseline parameters following response to therapy are being re-evaluated in an attempt to localize etiological factors responsible for the resistant state.

"Diabetes in Pregnancy" will also be presented by Dr. Boshell Monday, May 8 at 3:40 P.M. The following is a precis of his paper:

Less than a half century ago, successful pregnancy in a young diabetic patient was a rare thing, indeed. First of all, not many of the juvenile diabetics lived to the child-bearing age and those who did were seldom fertile. The occasional one who became pregnant seldom had a happy ending, usually losing the child and frequently her own life. Fortunately, this situation has been reversed but many problems remain. Why does the diabetic, even before the onset of diabetes, have such a high incidence of: (1) large babies, (2) stillborn fetuses, (3) toxemia, and (4) hydramnios?

Why do women who have been pregnant have a higher incidence of diabetes than their nulliparous colleagues?

**Make Your Plans Now to Hear These Excellent
Guest Speakers at the**

**107th Annual Session
of the**

Medical Association of Georgia

May 7-10, 1961 Atlanta Biltmore Hotel Atlanta, Georgia

The Program

SUNDAY AFTERNOON, MAY 7

Social Events

(Not a part of Official Program)

Sunday Noon, May 7

NOTE: Make reservations in advance with chairman if possible.

- 11:00 Georgia Pediatric Society Social Hour
Crystal Lounge
(Courtesy of Ross Laboratories)
- 12:00 Georgia Pediatric Society Luncheon
Ballroom
J. H. Patterson, Atlanta, Chairman

2:00 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS AND GUESTS INVITED)

Main Meeting Room

PRESIDING

Milford B. Hatcher, President

NOMINATION OF OFFICERS AND COUNCILORS
(Announcement of Tellers Committee)

President-Elect

First Vice President

Second Vice President

AMA Delegate (Term beginning January 1, 1962)

AMA Alternate Delegate (Term beginning January 1, 1962)

First District Councilor (To serve until 1964)

First District Vice Councilor (To serve until 1964)

Second District Councilor (To serve until 1964)

Second District Vice Councilor (To serve until 1964)

Third District Councilor (To serve until 1964)

Third District Vice Councilor (To serve until 1964)

Fourth District Councilor (To serve until 1964)

Fourth District Vice Councilor (To serve until 1964)

Georgia Medical Society Councilor (To serve until 1964)

Georgia Medical Society Vice Councilor (To serve until 1964)

Muscogee County Medical Society Councilor (To serve until 1962)

Muscogee County Medical Society Vice Councilor (To serve until 1962)

Bibb County Medical Society Councilor (To serve until 1963)

Bibb County Medical Society Vice Councilor (To serve until 1963)

- Fulton County Medical Society Councilor (To serve until 1963)
- Fulton County Medical Society Vice Councilor (To serve until 1963)
- Richmond County Medical Society Councilor (To serve until 1963)
- Richmond County Medical Society Vice Councilor (To serve until 1963)

NOMINATIONS FOR AWARDS

GENERAL PRACTITIONER OF THE YEAR AWARD

(To be voted on by the House of Delegates)

HARDMAN AWARD

(To be voted on by the House of Delegates)

2:30 Georgia Academy of General Practice Board of Directors Meeting

Room 1011

PRESIDING

Albert L. Morris, Fairburn

2:30 Orthopedic Section Meeting

(ALL PHYSICIANS INVITED)

Mezzanine Room 10

PRESIDING

J. H. Kite, Atlanta

2:30 MAJOR LIGAMENTOUS INJURIES OF THE LOWER EXTREMITY

George Whatley, Columbus

Discusser:

E. B. Dunlap, Atlanta

3:00 BASEBALL FINGERS

Augustin S. Carswell, Augusta

Discusser:

Louis G. Bayne, Atlanta

3:30 SLIPPED CAPITAL FEMORAL EPIPHYSIS

Floyd E. Bliven, Jr., Augusta

Discusser:

J. H. Kite, Atlanta

4:00 THE SERRATO ROD: ITS INDICATIONS AND TECHNIQUE ON FRACTURES OF ONE OR BOTH BONES OF THE FOREARM

J. C. Serrato, Jr., Columbus

Discusser:

Joe L. Kurtz, Atlanta

4:30 THE PHYSICIAN'S RESPONSIBILITY IN ATHLETIC INJURIES

Fred L. Allman, Jr., Atlanta

Discusser:

Jack Hughston, Columbus

2:30 EENT and Anesthesiology Joint Section Meeting

(ALL PHYSICIANS INVITED)

Auditorium, Academy of Medicine

PRESIDING

John E. Steinhaus, Atlanta

2:30 PRACTICAL AIDS TO MINIMIZE EMOTIONAL TRAUMA IN ELECTIVE SURGERY IN CHILDREN (including movie)

Martha McCranie, Augusta

- 3:00 TOXICITY OF LOCAL ANESTHETICS
Charles R. Allen, Galveston
PRESIDING
James T. King, Atlanta
- 4:00 AN OPERATION FOR REMOVAL OF DIS-
LOCATED LENSES: A FOLLOW-UP REPORT
F. Phinzy Calhoun, Jr., Atlanta
- 4:20 MYTHICAL SPHENOPALATINE GANGLION
NEURALGIA
Lester A. Brown, Atlanta

2:30 Pediatrics and Psychiatry Joint Section Meeting

(ALL PHYSICIANS INVITED)

Main Meeting Room

PRESIDING

Rives Chalmers, Atlanta

- 2:30 COMMON EMOTIONAL PROBLEMS IN EARLY
CHILDHOOD RELATED TO PHYSICAL AND
SEXUAL DEVELOPMENT
Barbara Korsch, New York City
- 3:10 DISTORTIONS OF DEVELOPMENT DUE TO
PSYCHOLOGICAL STRESS
Ralph Rabinovitch, Northville, Michigan
- 3:50 INTERMISSION—VIEW EXHIBITS
- 4:00 DISCUSSION WITH SPEAKERS PARTICIPATING

2:30 Radiology Section Meeting

(ALL PHYSICIANS INVITED)

Mezzanine Rooms 14-15

PRESIDING

William H. Somers, Macon

- 2:30 PREPARATION OF THE COLON FOR BARIUM
—AIR CONTRAST EXAMINATION
Robert E. Wise, Boston, Massachusetts
- 2:45 RE-EVALUATION AND APPLICATION OF IN-
TERPOSED NON-METALLIC FILTERS IN
DIAGNOSTIC RADIOLOGY
John J. Douglas, LaGrange
- 3:00 THE STOMACH AIR BUBBLE ON CHEST
FILMS OF CHILDREN
Russell Wigh and
Henry S. Anderson, Augusta
- 3:15 A METHOD OF RECORDING FLUOROSCOPIC
RADIATION EXPOSURE
Mr. William B. Miller, Mr. James W. Kin-
ard, Robert H. Rohrer, Ph.D., and H.
Stephen Weens, Atlanta
- 3:30 INTRA-OSSEOUS VENOGRAPHY—INDICA-
TIONS, TECHNIQUES, AND INTERPRETATION
Robert E. Wise, Boston, Massachusetts
- 4:00 FILM INTERPRETATION SESSION
MODERATOR
Ted F. Leigh, Atlanta
- PANEL
Robert E. Wise, Boston, and
State Radiologists

4:40 Georgia Society of Ophthalmology and Otolaryngology Business Meeting

Followed by Reception in Library 5:30-
6:30

Auditorium, Academy of Medicine

PRESIDING

W. P. Rhyne, Albany

4:40 Georgia Society of Anesthesiologists Business Meeting

Followed by Reception in Men's Lounge,
5:30-6:30

Men's Lounge, Academy of Medicine

PRESIDING

Walter F. Homeyer, Macon

4:45 MAG Delegates Registration

Main Meeting Room Entrance

5:00 House of Delegates Meeting

Main Meeting Room

PRESIDING

Thomas W. Goodwin, Augusta,

Speaker of the House

5:05 ORDER OF BUSINESS (See Delegate's Hand- book)

REPORT OF PRESIDENT WOMAN'S AUXILI-
ARY TO MAG

Mrs. W. P. Rhyne, Albany

5:45 YOUR AMA—1961

Leonard W. Larson, Bismarck, North

Dakota, President-Elect, American

Medical Association

6:30 House of Delegates and Exhibitors Social Hour

Georgian Ballroom

Social Events

(Not a part of Official Program)

Sunday Night, May 7

NOTE: Make reservations in advance with chairman
if possible.

- 5:00 Georgia Pediatric Society Social Hour
Pompeian Room
(Courtesy of Mead Johnson)
- 5:30 Georgia Society of Ophthalmology and
Otolaryngology Reception
Library, Academy of Medicine
J. T. King, Atlanta, Chairman
- 5:30 Georgia Society of Anesthesiologists
Reception
Men's Lounge, Academy of Medicine
J. E. Steinhaus, Atlanta, Chairman
- 5:30 Georgia Psychiatric Association Social Hour
and Dinner
Room 403, Atlanta Athletic Club
John Warkentin, Atlanta, Chairman
- 6:00 Georgia Society of Dermatologists Social Hour
and Dinner
Piedmont Driving Club, Tack Room
W. L. Dobes, Atlanta, Chairman
- 6:30 Georgia Orthopedic Society Dinner
Hugh Howell's Country Estate
Wood Lovell, Atlanta, Chairman
- 7:00 Class of 1936, Medical College of Georgia,
25th Anniversary Reunion Social Hour and
Dinner (Stag)
Academy of Medicine Dining Room
J. T. King, Atlanta, Chairman
- 7:00 Georgia Radiological Society Social Hour and
Dinner
Rooms 1015-1016
J. Frank Walker, Atlanta, President and
Chairman

MONDAY MORNING, MAY 8

8:00 MAG Reference Committees

- 8:00 REFERENCE COMMITTEE NO. 1
(Room to be announced)
8:00 REFERENCE COMMITTEE NO. 2
(Room to be announced)
8:00 REFERENCE COMMITTEE NO. 3
(Room to be announced)

9:00 Surgery, Anesthesiology and Radiology Joint Section Meeting

(ALL PHYSICIANS INVITED)
Main Meeting Room
PRESIDING

- John E. Steinhaus, Atlanta
9:00 GENERAL ANESTHESIA WITH HALOTHANE
John M. Brown, Atlanta
9:20 MUSCLE RELAXANTS FOR ABDOMINAL PROCEDURES
Charles R. Allen, Galveston, Texas
PRESIDING
Ted F. Leigh, Atlanta
9:50 INTRAVENOUS CHOLANGIOGRAPHY, A SURGICAL EVALUATION
Robert E. Wise, Boston, Massachusetts
PRESIDING
David Henry Poer, Atlanta
10:20 THE SURGICAL SIGNIFICANCE OF THE NON-VISUALIZING GALLBLADDER
S. A. Roddenbery, Columbus
10:40 SURGERY IN THE PSYCHIATRIC PATIENT
Hoke Wammock, Carlos R. Triana, and Hernando Ortega, Augusta
11:00 CURRENT ATTITUDES ON THE TREATMENT OF PEPTIC ULCER
Mark M. Ravitch, Baltimore, Maryland
11:40 SOFT TISSUE INJURIES OF THE FACE AND THEIR REPAIR
John R. Lewis, Atlanta

9:00 Medicine, Diabetes, and Dermatology Joint Section Meeting

(ALL PHYSICIANS INVITED)
Georgian Ballroom
PRESIDING

- William L. Dobes, Atlanta
9:00 MONILIAL GRANULOMA TREATED WITH AMPHOTERICIN B
Marvin F. Engel, Brunswick
9:15 A CLINICIAN'S VIEW OF ANABOLIC STEROIDS
Roy A. Wiggins, Jr., Atlanta
9:30 PRECANCEROUS SKIN LESIONS
Ray O. Noojin, Birmingham, Alabama
10:00 PSORIASIS
William L. Dobes, Atlanta
PRESIDING
Bernard P. Wolff, Atlanta
10:30 GEORGIA HEART ASSOCIATION LECTURE
NONCARDIAC VASCULAR DISORDERS OF THE THORAX
Sol Katz, Washington, D. C.
11:00 MYXEDEMA—SUBTLE SIGNS AND SYMPTOMS
E. G. Herndon, Atlanta

- 11:15 FOOD ALLERGY AS A CAUSE OF BRONCHIAL ASTHMA

Lamar B. Peacock, Atlanta

- 11:30 TEN CASES OF INSULIN RESISTANT DIABETES—CLINICAL AND EXPERIMENTAL STUDY

Boris Boshell, Birmingham, Alabama

- 11:45 THE TREATMENT OF SEVERE AND MALIGNANT HYPERTENSION WITH GUANETHIDINE ALONE AND IN COMBINATION WITH OTHER HYPOTENSIVE AGENTS

Louis L. Battey, J. Edwin Wood, and Julian Williams, Augusta

9:00 Urology, Obstetrics, and Gynecology Joint Section Meeting

(ALL PHYSICIANS INVITED)
Mezzanine Room
PRESIDING

- Charles Eberhart, Atlanta
9:00 FUNCTIONAL OBSTRUCTION OF THE VESICAL NECK IN ADULTS
James W. Morgan and Charles Eberhart, Atlanta
9:30 THE RADICAL VAGINAL OPERATION FOR CARCINOMA OF THE CERVIX IN MODERN GYNECOLOGIC PRACTICE
Milton L. McCall, Pittsburgh, Pennsylvania
(To be followed by motion picture)
10:30 PHYSIOLOGY OF THE URINARY SPHINCTER AND ITS RELATIONSHIP TO OPERATIONS FOR STRESS INCONTINENCE
Jack Lapides, Ann Arbor, Michigan
11:00 VESICoureTERAL REFLUX IN CHILDREN
J. G. Palmer and Donald R. Rooney, Marietta
11:30 TRICHOMONAS VAGINITIS: EPIDEMIOLOGY STUDIES
W. L. Southerland, D. F. Mullins, Jr., and C. I. Bryans, Jr., Augusta
12:00 REFLEX ANURIA FOLLOWING RETROGRADE PYELOGRAPHY
Jay R. Johnson and Rafe Banks, Gainesville

9:00 Pediatrics and Psychiatry Joint Section Meeting

(ALL PHYSICIANS INVITED)
Mezzanine Room 10
PRESIDING

- Joseph H. Patterson, Atlanta
9:00 READING RETARDATION—A PSYCHIATRIC, NEUROLOGICAL, AND EDUCATIONAL APPROACH
Ralph Rabinovitch, Northville, Michigan
DISCUSSION FROM FLOOR
10:20 INTERMISSION—VIEW EXHIBITS
10:35 REACTION OF CHILDREN TO CHRONIC ILLNESS AND PROLONGED HOSPITALIZATION
Barbara Korsch, New York City
DISCUSSION FROM FLOOR

Visit the Commercial Exhibits. They Support your Annual Session.

**9:00 Georgia Association of Pathologists
Business Session**
Mezzanine Rooms 5-6
PRESIDING
J. T. Godwin, Atlanta

MONDAY AFTERNOON, MAY 8

12:00 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS AND
GUESTS INVITED)

Main Meeting Room

PRESIDING

Milford B. Hatcher, Macon, President,
Medical Association of Georgia

12:00 INVOCATION

12:05 WELCOME

J. G. McDaniel, Atlanta, President,
Fulton County Medical Society
Honorable William B. Hartsfield, Atlanta,
Mayor of Atlanta

PRESIDING

Simone Brocato, Columbus,
First Vice President

REPORT OF THE PRESIDENTIAL YEAR 1960-
1961

Milford B. Hatcher, Macon, President

OUR ASSOCIATION FUTURE FOR 1961-1962

Fred H. Simonton, Chickamauga,
President-Elect

2:30 MAG Reference Committees

2:30 REFERENCE COMMITTEE No. 4
(Room to be announced)

2:30 REFERENCE COMMITTEE No. 5
(Room to be announced)

2:30 Surgery and Urology Joint Section Meeting

(ALL PHYSICIANS INVITED)

Georgian Ballroom

PRESIDING

David Henry Poer, Atlanta

2:30 TECHNIQUES OF VENTRAL HERNIA REPAIR

Mark M. Ravitch, Baltimore, Maryland

3:00 SURGICAL MANAGEMENT OF VARICOSE
VEINS AND POST-PHLEBITIC SYNDROME

P. C. Shea, Jr., Atlanta

3:15 AN APPRAISAL OF FIFTEEN YEARS OF EX-
TENDED PELVIC SURGERY

Sam A. Wilkins, Jr., James F. Kirkpatrick,
Jr., and Alexander S. Haraszti, Atlanta

3:30 ISCHIAL APOPHYSITIS

Lester Harbin, J. M. Kelley, Rome, and
F. E. Bliven, Jr., Augusta

4:00 USE OF RENAL FUNCTION TESTS IN SURGI-
CAL PRACTICE

Jack Lapides, Ann Arbor, Michigan

4:15 TRANSURETHRAL PROSTATECTOMY,
PRESENT DAY STATUS

Harold P. McDonald, W. E. Upchurch, and
Carlos Celaya, Atlanta

4:30 TRAUMA TO THE URINARY BLADDER
E. M. Nicholas, Atlanta

Social Events

(Not a part of Official Program)

Monday Noon, May 8

NOTE: Make reservations in advance with chairman
if possible.

11:00 Georgia Thoracic Society and Georgia Chap-
ter, American College of Chest Physicians
Meeting

Atlanta Biltmore, Rooms 1008-1009

Joseph S. Cruise, Atlanta, Chairman

12:00 Georgia Thoracic Society and Georgia Chap-
ter, American College of Chest Physicians
Luncheon

Atlanta Biltmore, Room 1016

Joseph S. Cruise, Atlanta, Chairman

12:00 Georgia Radiological Society Business
Meeting and Luncheon

Atlanta Biltmore Hotel, Room 1015

Ted F. Leigh, Atlanta, Chairman

12:30 Georgia Orthopedic Society Luncheon
Capital City Club

Thomas P. Goodwin, Atlanta, Chairman

12:30 Georgia Association of Pathologists
Luncheon

Atlanta Biltmore Hotel, Room 14

Vince Bell, Atlanta, Chairman

1:00 Georgia State Obstetrical and Gynecological
Society Luncheon

Pompeian Room

George Williams, Atlanta, Chairman

1:00 Georgia Urological Association Luncheon
Atlanta Biltmore Hotel, Room 1010

Tom Florence, Atlanta, Chairman

2:30 Chest, Radiology, and Medicine Joint Section Meeting

(ALL PHYSICIANS INVITED)

Main Meeting Room

PRESIDING

C. F. McCuiston, Atlanta

2:30 PATTERNS OF HISTOPLASMOSIS

Sol Katz, Washington, D. C.

2:50 AN OBJECTIVE APPRAISAL OF SOME PA-
TIENTS WITH CONGENITAL INTRACARDIAC
DEFECTS WHO HAVE HAD OPEN HEART
SURGERY

Robert H. Franch, Atlanta

3:10 SURGICAL TREATMENT OF ISOLATED PUL-
MONARY AND INFUNDIBULAR STENOSIS, US-
ING EXTRACORPOREAL CIRCULATION

Richard King, James B. Minor,
William A. Hopkins, M. B. Davis, Jr.,
William C. Wansker, and Lester Rumble,
Jr., Atlanta

3:30 A STUDY OF 500 CASES OF CARCINOMA OF
THE LUNG

Osler A. Abbott, William E. Van Fleit, and
Michael F. Sawwan, Atlanta

4:00 PATHOGENESIS AND TREATMENT OF
PULMONARY EMPHYSEMA

Andrew L. Banyai, Chicago, Illinois

4:30 INTERMISSION—VIEW EXHIBITS

- 4:45 **PANEL: CHEST DISEASE**
MODERATOR:
 Ross L. McLean, Atlanta
PANELISTS:
 Andrew L. Banyai, Chicago, Illinois
 Robert E. Wise, Boston, Massachusetts
 Osler A. Abbott, Atlanta

2:30 Obstetrics and Gynecology Section Meeting

(ALL PHYSICIANS INVITED)
Mezzanine Room
PRESIDING

- William K. Jordan, Macon
 2:30 **MATERNAL MORTALITY, GRADY MEMORIAL HOSPITAL**
 John D. Thompson, Atlanta
 3:00 **EXPERIENCES IN MANAGEMENT OF SEVERE TOXEMIAS OF PREGNANCY**
 Milton L. McCall, Pittsburgh, Pennsylvania
 3:30 **HYPOFIBRINOGENEMIA IN PREGNANCY**
 T. E. Rogers, Jr., Macon
 4:00 **PANEL: GYNECOLOGIC PROBLEM CASES**
PRIMARY RHABDOMYOSARCOMA OF THE VAGINA
 Jack Spanier, Atlanta
VAGINITIS EMPHYSEMATOSA
 George Sommers, Atlanta
INTROITAL STENOSIS FROM VULVAR ENDOMETRIOSIS FOLLOWING VULVECTOMY
 Donald Sondag, Atlanta
MODERATOR:
 Albert J. Kelly, Savannah
PANELISTS:
 Milton L. McCall, Pittsburgh
 Hugh Bickerstaff, Columbus
 Frederick Zuspan, Augusta

2:30 Pediatrics and Orthopedics Joint Section Meeting

(ALL PHYSICIANS INVITED)
Mezzanine Room 10
PRESIDING

- Olin Shivers, Atlanta
 Fred Murphy, Thomasville, Co-Chairman
 2:30 **EPIPHYSEAL INJURIES IN CHILDREN WITH SUBSEQUENT GROWTH DISTURBANCE**
 Thomas P. Waring, Savannah
DISCUSSER:
 F. James Funk, Atlanta
 3:00 **VITAMIN D RESISTANT RICKETS**
 J. H. Kite, Atlanta
PATHOLOGY OF VITAMIN D RESISTANT RICKETS WITH AUTOPSY REPORT ON ONE OF THE ABOVE CASES
 James W. Harkess, Augusta
DISCUSSER:
 David Morgan, Augusta
 3:30 **INTERMISSION—VIEW EXHIBITS**
 3:45 **CALCIFICATION OF CERVICAL INTERVERTEBRAL DISCS IN CHILDREN—REPORT OF A CASE AND REVIEW OF LITERATURE**
 Cheney C. Sigman, Jr., and
 Charles M. Silverstein, Atlanta
DISCUSSER:
 H. S. Weens, Atlanta

- 4:15 **MODERN TREATMENT OF HYDROCEPHALUS**
 Fleming Jolley, Atlanta
DISCUSSER:
 Robert Mabon, Atlanta

2:30 Pathology Section

(ALL PHYSICIANS INVITED)
Mezzanine Rooms 5-6
PRESIDING

- Hugh V. Bell, Jr., Atlanta
 2:30 **A BLOOD PROGRAM FOR THE STATE OF GEORGIA**
 Lester Forbes, Atlanta
 3:00 **METHODS OF DETECTING ANTIBODIES IN SERUMS**
 James J. Griffiths, Miami, Florida
 3:30 **SOME PROBLEMS IN HOSPITAL BLOOD BANKING**
 Walter L. Sheppard, Augusta
 3:50 **INTERMISSION—VIEW EXHIBITS**
 4:00 **CLINICAL USES OF SPECIALLY PREPARED BLOOD TRANSFUSIONS**
 Charles M. Huguley, Jr., Atlanta
 4:30 **BLOOD FOR OPEN HEART SURGERY**
 Charles C. Corley, Atlanta

5:30 Georgia Radiological Society Business Meeting

Main Meeting Room
PRESIDING

J. Frank Walker, Atlanta, President

MONDAY NIGHT, MAY 8

Social Events

(Not a part of Official Program)

Monday Night, May 8

NOTE: Make reservations in advance with chairman if possible.

- 6:30 **Medical College of Georgia Alumni Social Hour and Dinner**
 (Time and place to be announced)

Changes are always made after the printing of the program in the Journal. Be sure to check the Official Program for these changes.

TUESDAY MORNING, MAY 9

Social Events

(Not a part of Official Program)

Tuesday Morning, May 9

NOTE: Make reservations in advance with chairman if possible.

- 7:30 Georgia Society of Clinical Hypnosis
Breakfast
Davis Cafeteria, 820 West Peachtree St., N.W.
Harry Lipton, Atlanta, Chairman

9:00 General Session (G.P. Day)

(ALL PHYSICIANS INVITED)

Main Meeting Room

PRESIDING

Clifton G. Kemper, Atlanta

9:00 VACCINE THERAPY

Jack C. Norris, Atlanta

9:20 DISCUSSION INVESTMENTS, STOCKS AND BONDS

Mr. Darwin Charles Fenner, Atlanta,
Merrill Lynch, Pierce, Fenner, and Smith

9:50 SOME MEDICOLEGAL CONTRIBUTIONS OF THE GENERAL PRACTITIONER

Mr. George E. Hall, Chicago, Illinois, AMA
Director, Department of Legal Medicine

10:20 PERFUSION IN MALIGNANCY

Edgar D. Grady and
Luther Rollins, Atlanta

11:00 TRANSFUSION REACTIONS

James J. Griffiths, Miami, Florida

11:30 THE NON-HOSPITAL GENERAL PRACTICE OF MEDICINE

Reid Gullatt, Cochran

TUESDAY AFTERNOON, MAY 9

12:00 Abner W. Calhoun Memorial Lectureship

(ALL PHYSICIANS INVITED)

Main Meeting Room

PRESIDING

Henry H. Tift, Macon

12:00 BIRTHDAYS AND HEART DISEASE

Tinsley Harrison, Birmingham, Alabama

**Be prompt to your meetings—Late-
comers are always distracting!**

Social Events

(Not a part of Official Program)

Tuesday Afternoon, May 9

NOTE: Make reservations in advance with chairman if possible.

- 12:30 Georgia Academy of General Practice
Luncheon

Atlanta Biltmore Hotel, Room 1015

J. V. Pierotti, Atlanta, Chairman

- 12:30 Georgia Chapter, American College of
Surgeons Luncheon

Pompeian Room

W. A. Hopkins, Atlanta, Chairman

2:30 General Session (G.P. Day)

(ALL PHYSICIANS INVITED)

Main Meeting Room

PRESIDING

Joseph B. Mercer, Brunswick

2:30 RADIOLOGICAL DIAGNOSIS OF POLYPS OF THE COLON

Robert E. Wise, Boston, Massachusetts

3:00 ELECTROLYTES

Neil G. Perkinson, Atlanta

3:20 SOME SKIN MANIFESTATIONS OF INTERNAL DISEASE

Sidney Olansky, Atlanta

3:40 DIABETES IN PREGNANCY

Boris R. Boshell, Birmingham, Alabama

4:10 RESPIRATORY PROBLEMS IN THE NEWBORN

W. E. Laupus, Augusta

4:30 PANEL DISCUSSION OF CHEMOTHERAPY IN MALIGNANCY

MODERATOR:

Spencer Brewer, Atlanta

PANELISTS:

Charles M. Huguley, Atlanta

Charles C. Corley, Atlanta

WEDNESDAY, MAY 10

8:30 Medical-Legal Workshop

(BY REGISTRATION FEE ONLY)

Grady Hospital Auditorium, 80 Butler
Street, S.E.

PRESIDING

Herman D. Jones, Ph.D., Atlanta, Director,
Crime Laboratory, State of Georgia

9:00 TRAUMATIC INJURIES: CUTTING, STAB, AND GUNSHOT

Geoffrey T. Mann, Richmond, Virginia, Chief
Medical Examiner of Virginia

1:00 HIDDEN CAUSES OF DEATH

Richard Ford, Boston, Massachusetts,
Chief Medical Examiner of Boston

3:00 INVESTIGATION AND EXAMINATION OF DIS- INTERRED BODIES

Milton Helpen, New York City, Chief
Medical Examiner of New York City

4:30 FORENSIC MEDICINE AND THE AMA
Mr. George E. Hall, Chicago, Illinois, AMA
Director, Department of Legal Medicine
5:00 ASPECTS OF GEORGIA POST MORTEM ACT
Herman D. Jones, Ph.D., Atlanta

9:00 House of Delegates Second Meeting

Main Meeting Room

PRESIDING

Thomas W. Goodwin, Augusta,
Speaker of the House

ORDER OF BUSINESS

(See Delegates Handbook)

11:00 MAG General Business Session

(ALL MAG AND AUXILIARY MEMBERS AND
GUESTS INVITED)

Main Meeting Room

PRESIDING

Milford B. Hatcher, Macon, President,
Medical Association of Georgia

PRESENTATION OF 50-YEAR CERTIFICATES

Luther H. Wolff, Columbus, Immediate Past
President, Medical Association of Georgia

PRESENTATION OF SCIENTIFIC EXHIBIT
AWARDS

Ted F. Leigh, Atlanta, Chairman,
Scientific Awards Committee

PRESENTATION OF GENERAL PRACTITIONER
OF THE YEAR AWARD

Joseph B. Mercer, Brunswick, President,
Georgia Academy of General Practice

PRESENTATION OF MAG CERTIFICATES OF
APPRECIATION

John T. Mauldin, Atlanta, Secretary,
Medical Association of Georgia

PRESENTATION OF HARDMAN AWARD

Fred H. Simonton, Chickamauga,
President-Elect, Medical Association
of Georgia

PRESENTATION OF MAG DISTINGUISHED
SERVICE AWARD

Milford B. Hatcher, Macon, President,
Medical Association of Georgia

SELECTION OF SITE FOR ANNUAL MEETING
1962

ANNOUNCEMENT OF MAG ELECTION RE-
SULTS

Chairman, Tellers Committee

INSTALLATION OF 1961-1962 OFFICERS

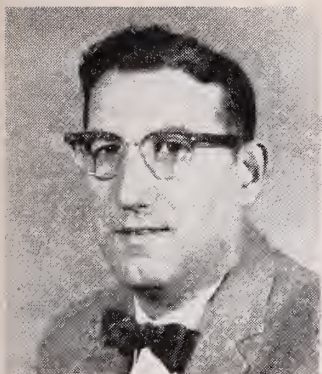
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ADJOURNMENT OF 107TH ANNUAL SESSION

Your Time Is Valuable
Make Good Use of It
By Attending
The 107th Annual Session
of the
Medical Association of Georgia
Atlanta Biltmore Hotel

May 7-10, 1961

Atlanta, Georgia



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*attains
sustains
retains*

*extra
antibiotic
activity*

DEC

attains activity
levels promptly

DECLOMYCIN Demethylchlortetracycline attains — usually within two hours—blood levels more than adequate to suppress susceptible pathogens—on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity
levels evenly

DECLOMYCIN Demethylchlortetracycline sustains through the entire therapeutic course, the high activity levels needed to control the primary infection and to check secondary infection at the original—or another—site. This combined action is usually sustained without the pronounced hour-to-hour, dose-to-dose, peak-and-valley fluctuations which characterize other tetracyclines.

TETRACYCLINE
ACTIVITY
WITH
DECLOMYCIN
THERAPY

DOSAGE
150 mg. q.i.d.

TETRACYCLINE
ACTIVITY
WITH OTHER
TETRACYCLINE
THERAPY

DOSAGE
250 mg. q.i.d.

DECLOMYCIN—SUSTAINED ACTIVITY LEVELS

OTHER TETRACYCLINES—PEAKS AND VALLEYS

POSITIVE ANTIBACTERIAL ACTION

PROTECTION AGAINST PROBLEM PATHOGENS

LOMYCIN[®]

DEMETHYLCHLORTETRACYCLINE LEDERLE

retains activity
levels 24-48 hrs.

DECLOMYCIN Demethylchlortetracycline retains activity levels up to 48 hours after the last dose is given. At least a full, extra day of positive action may thus be confidently expected. The average, daily adult dosage for the average infection—1 capsule q.i.d.—is the same as with other tetracyclines...but **total** dosage is lower and duration of action is longer.

CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

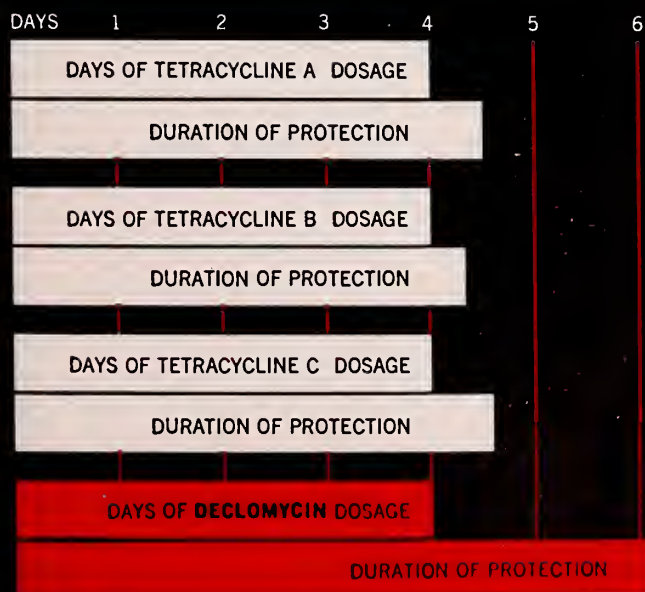
SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.



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 Ted F. Leigh, Atlanta, *Scientific Exhibits and Meeting Rooms*
 Mark S. Dougherty, Jr., Atlanta
 Linton H. Bishop, Jr., Atlanta
 Mrs. E. W. Waldemeyer, Americus, *Ex-officio*

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 Lamar Glass
 Margaret J. Wall
 Julian Z. Watters
 F. James Funk
 D. O. Thompson
 Francis W. Fitzhugh

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- 44—McDUFFIE**
Henry M. Althisar, Thomson, President
Ernest Lawrence Cook, Thomson, Secretary
- 45—MERIWETHER-HARRIS**
H. S. Raper, Warm Springs, President
H. Calvin Jackson, Manchester, Secretary
- 46—MITCHELL**
L. E. Hackett, Camilla, President
A. A. McNeill, Jr., Camilla, Secretary
- 47—MUSCOGEE**
Edgar B. Horn, Columbus, President
Bruce C. Newsom, Columbus, Secretary
Mrs. Barbara S. Walden, Columbus, Exec. Sec.
- 48—NEWTON-ROCKDALE**
J. R. Sams, Covington, President
J. W. Purcell, Jr., Covington, Secretary
- 49—OCONEE VALLEY**
J. H. Nicholson, Madison, President
Kendrick Lewis, Madison, Secretary
- 50—OCMULGEE**
Reid Gullatt, Cochran, President
Blake S. Bivins, Cochran, Secretary
- 51—POLK**
Raymond F. Spanjer, Cedartown, President
Charles M. Smith, Rockmart, Secretary
- 52—RABUN**
J. C. Dover, Clayton, Secretary
- 53—RANDOLPH-TERRELL**
Charles M. Ward, Dawson, President
Robert B. Martin III, Cuthbert, Secretary
- 54—RICHMOND**
John B. Bowen, Augusta, President
W. N. Agostas, Augusta, Secretary
Mr. Leonard M. Morris, Augusta, Exec. Sec.
- 55—SCREVEN**
Katrine Rawls Hawkins, Sylvania, President
J. C. Paul, Sylvania, Secretary
- 56—SOUTH GEORGIA**
Van Bennett, Valdosta, President
John Marvin Miller, Valdosta, Secretary
- 57—SOUTHEAST GEORGIA**
James E. Barfield, Vidalia, President
Herbert D. Smith, Mt. Vernon, Secretary
- 58—SOUTHWEST GEORGIA**
James H. Crowdis, Jr., Blakely, President
Robert E. Jennings, Arlington, Secretary
- 59—SPALDING**
Jack L. Austin, Griffin, President
Ira H. Slade, Jr., Griffin, Secretary
Mrs. Mary A. Roddy, Griffin, Exec. Sec.
- 60—STEPHENS**
Irving D. Hellenga, Toccoa, President
Robert E. Thompson, Toccoa, Secretary
- 61—SUMTER**
R. A. Collins, Americus, President
Frank A. Wilson, III, Leslie, Secretary
- 63—TAYLOR**
R. C. Montgomery, Butler, President
E. C. Whatley, Reynolds, Secretary
- 64—TELFAIR**
Fred A. Smith, Jr., McRae, President
Duncan B. McRae, McRae, Secretary
- 65—THOMAS-BROOKS**
Warren A. Taylor, Thomasville, President
Julian B. Neel, Thomasville, Secretary
- 66—TIFT**
Paul Warren Lucas, Tifton, President
Tom Edmondson, Tifton, Secretary
- 68—TROUP**
Curran S. Easley, Jr., LaGrange, President
J. T. Mitchell, LaGrange, Secretary
- 69—UPSON**
J. M. Kellum, Thomaston, President
James A. Woodall, Thomaston, Secretary
- 70—WALKER-CATOOSA-DADE**
Jerome P. Sims, Ft. Oglethorpe, President
Leroy Sherrill, Rossville, Secretary
- 71—WALTON**
Harry B. Nunnally, Monroe, President
Stevens Byars, Monroe, Secretary
- 72—WARE**
Neal F. Yeomans, Waycross, President
Henry T. Adkins, Waycross, Secretary
- 73—WARREN**
H. B. Cason, Warrenton, President
A. W. Davis, Warrenton, Secretary
- 74—WASHINGTON**
F. T. McElreath, Jr., Tennille, President
William Rawlings, Sandersville, Secretary
- 75—WAYNE**
Carter Lee Meadows, Jesup, President
Fred M. Harper, Jesup, Secretary
- 76—WHITFIELD**
Paul L. Bradley, Dalton, President
Sidney L. Sellers, Dalton, Secretary
Mrs. John E. Lord, Dalton, Exec. Sec.
- 78—WILKES**
H. Wilbur Harper, Jr., Warrenton, President
Harry L. Cheves, Jr., Union Point, Secretary
- 79—WORTH**
J. L. Tracy, Jr., Sylvester, President
H. G. Davis, Jr., Sylvester, Secretary

Woman's Auxiliary to the Medical Association of Georgia

36th Annual Meeting

May 7-10, 1961 — Atlanta



Mrs. W. P. Rhyne

President's Invitation

Members of the Woman's Auxiliary to the Medical Association of Georgia, it is my privilege to extend to you a cordial invitation to attend the 36th Annual Convention of the Auxiliary to the Medical Association of Georgia to be held in Atlanta, Georgia, May 7-10, 1961.

The meeting is planned to enlighten you with what has been done in your state Auxiliary this year, to inspire us to greater achievements in the future, and entertainment for your pleasure and participation.

Mrs. W. P. Rhyne

President, Woman's Auxiliary to the
Medical Association of Georgia

Welcome to Atlanta

It is with great pleasure that we welcome you to the Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

We have planned entertainment for you that we hope will be most enjoyable and will make your visit to Atlanta very pleasant. We hope that you will participate in all of these activities.

Sincerely,

Mrs. William A. Hopkins

President, Woman's Auxiliary to the
Fulton County Medical Society



Mrs. William A. Hopkins

ORGANIZATION

of the

Woman's Auxiliary to the Medical Association of Georgia

Officers, 1960-1961

President—Mrs. W. P. Rhyne.....Albany
 President-Elect—Mrs. A. Worth Hobby.....Atlanta
 First Vice-President—Mrs. Ennis W. Waldemayer.....Americus
 Second Vice-President—Mrs. F. N. Harrison.....Augusta
 Third Vice-President—Mrs. W. Lynn Hicks.....Macon
 Corresponding Secretary—Mrs. W. P. Stoner.....Sylvester
 Recording Secretary—Mrs. Louie H. Griffin.....Claxton
 Treasurer—Mrs. George M. Hutto.....Columbus
 Historian—Mrs. E. Peter Inglis.....Marietta
 Parliamentarian—Mrs. Shelly C. Davis.....Atlanta

Advisory Committee

Virgil B. Williams, M.D., *Chairman*.....Griffin
 Milford B. Hatcher, M.D., *ex-officio*.....Macon
 W. G. Elliott, M.D.Cuthbert
 W. P. Rhyne, M.D.Albany
 Fred H. Simonton, M.D., *ex-officio*.....Chickamauga
 Luther H. Wolff, M.D.Columbus
 Remer Y. Clark, M.D.Marietta

Standing Committee Chairmen

Achievement Award—Mrs. Edgar M. Dunstan.....Decatur
 Archives—Mrs. Edward L. Askren, Jr.Atlanta
 American Medical Education Foundation—
 Mrs. Carl S. Pittman, Jr.Tifton
 Brawner Trophy—Mrs. Remer Y. Clark.....Marietta
 Budget and Finance—Mrs. John A. Meier.....Albany
 Bulletin—Mrs. Paul T. Russell.....Albany
 Bylaws and Procedures—Mrs. C. James Roper.....Jasper
 Civil Defense—Mrs. F. Kells Boland, Jr.Atlanta
 Community Service—Mrs. F. N. Harrison.....Augusta
 Doctor's Day—Mrs. Floyd R. Sanders.....Decatur
 Editorial—Mrs. James W. Morgan.....Atlanta
 Health Careers—Mrs. W. A. Mendenhall.....Chamblee
 Legislation—Mrs. W. Lynn Hicks.....Macon
 Membership—Mrs. A. Worth Hobby.....Atlanta
 Mental Health—Mrs. Rives Chalmers.....Atlanta
 Program—Mrs. Ennis W. Waldemayer.....Americus
 Research in Romance of Medicine—Mrs. Hayward S. Phillips.....Augusta
 Safety—Mrs. F. H. Thompson.....Americus
 Scrapbook—Mrs. Douglas L. Head.....Thomasston
 State Handbook—Mrs. John L. Elliott.....Savannah
 Student Loan Fund—Mrs. Charles L. Bryans.....Augusta
 Rural Health—Mrs. Robert H. Vaughan.....Columbus

District Councilors

First—Mrs. James L. Alexander.....Savannah
 Second—Mrs. Henry K. Jarrett.....Tifton
 Third—Mrs. Robert H. Vaughan.....Columbus
 Fourth—Mrs. J. W. Chambers.....LaGrange
 Fifth—Mrs. William J. Pendergrast.....Atlanta
 Sixth—Mrs. Curtis F. Veal.....Milledgeville
 Seventh—Mrs. David A. Wells.....Dalton
 Eighth—Mrs. C. R. Youmans.....St. Simons Island
 Ninth—Mrs. O. C. Pittman.....Commerce
 Tenth—Mrs. John L. Barner.....Athens

Councilor, Woman's Auxiliary to the Southern Medical Association

Mrs. Louis H. Griffin.....Claxton

County Auxiliary Presidents

Baldwin (Putnam)—Mrs. William Monroe.....Milledgeville
 Bibb (Crawford, Jones, Monroe, Twiggs, Wilkinson)—
 Mrs. Rudolph W. Jones, Jr.Macon
 Bulloch-Candler-Evans—Mrs. R. L. Pence.....Metter
 Carroll-Douglas-Haralson—Mrs. Claude V. Vansant, Jr.Douglasville
 Chatham-Georgia Medical Society (Bryan, Long, Liberty,
 Effingham, McIntosh)—Mrs. Oscar H. Lott.....Savannah
 Chattahoochee (Gwinnett, Forsyth)—
 Mrs. William Robert Dunn.....Cumming
 Chattooga—Mrs. William P. Martin.....Summerville
 Cherokee-Pickens—Mrs. Charles R. Andrews.....Canton
 Cobb—Mrs. Robert F. Klingbeil.....Marietta
 Coffee—Mrs. T. K. Stapleton.....Douglas
 Colquitt—Mrs. John F. McCoy.....Moultrie
 Crawford W. Long—Mrs. John L. Barner.....Athens
 Decatur-Seminole—Mrs. Robert J. Starling.....Donalsonville

DeKalb—Mrs. Fincher Powell.....Avondale Estates
 Dougherty—Mrs. Robert D. Waller.....Albany
 Elbert-Franklin-Hart—Mrs. Harold E. Campbell.....Elberton
 Flint (Crisp, Turner, Dooley)—Mrs. O. K. Coleman.....Cordele
 Floyd—Mrs. Robert M. Harbin, Jr.Rome
 Fulton—Mrs. William A. Hopkins.....Atlanta
 Glynn—Mrs. Joseph B. Mercer.....Brunswick
 Gordon—Mrs. Byron H. Steele.....Fairmount
 Habersham (Towns, White)—Mrs. Charles M. Henry.....Clarkesville
 Hall-Lumpkin—Mrs. John H. Reed.....Gainesville
 Jackson-Barrow—Mrs. Charles B. Skelton.....Winder
 Mitchell—Mrs. J. C. Brim.....Pelham
 Muscogee—Mrs. S. A. Roddenberry.....Columbus
 Ocmulgee (Bleckley, Dodge, Pulaski, Wilcox)—
 Mrs. Richard L. Smith.....Cochran
 Richmond (Columbia)—Mrs. W. N. Agostas.....Augusta
 South Georgia (Lowndes, Lanier, Berrien, Cook, Clinch)—
 Mrs. R. L. Stump.....Valdosta
 Southwest Georgia (Calhoun, Early, Baker, Clay)—
 Mrs. Hinton J. Merritt.....Colquitt
 Spalding (Butts, Lamar, Henry, Pike)—
 Mrs. James M. Skinner.....Griffin
 Stephens—Mrs. Irving D. Hellenga.....Toccoa
 Sumter-Schley-Macon-Marion—Mrs. Carl P. Savage.....Montezuma
 Thomas-Brooks—Mrs. E. E. Davis.....Thomasville
 Tift—Mrs. Eugene M. Flowers.....Tifton
 Troup-Heard—Mrs. William C. Tippin, Jr.Hogansville
 Upson—Mrs. Norman P. Gardner.....Thomasston
 Walker-Catoosa-Dade—Mrs. Louis A. Williams.....Ringgold
 Ware (Bacon, Brantley, Camden, Charlton, Jeff Davis, Pierce)—
 Mrs. S. W. Clark, Jr.Waycross
 Washington—Mrs. Marion W. Hurt.....Sandersville
 Wayne—Mrs. E. Lanier Harrell.....Jesup
 Whitfield-Murray—Mrs. Fort F. Felker, Jr.Dalton
 Worth—Mrs. Norman J. Crowe.....Sylvester

Past Presidents and Conventions

Honorary Presidents for Life

Mrs. James N. Brawner, Sr., Atlanta
 Mrs. Eustace A. Allen, Atlanta

1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta,
 Temporary Chairman
 1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta
 1926—Albany—Mrs. William H. Myers, Savannah
 1927—Athens—Mrs. C. W. Roberts, Atlanta
 1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney, S. C.)
 1929—Macon—Mrs. Charles C. Hinton, Macon
 1930—Augusta—Mrs. Marion T. Benson, Atlanta (Deceased)
 1931—Macon—Mrs. Charles C. Harrold, Macon (Deceased)
 1932—Savannah—Mrs. Ralston Lattimore, Savannah
 1933—Macon—Mrs. S. T. R. Revell, Louisville
 1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)
 1935—Atlanta—Mrs. J. E. Penland, Waycross
 1936—Savannah—Mrs. Ernest R. Harris, Winder (Deceased)
 1937—Macon—Mrs. W. R. Dancy, Savannah
 1938—Augusta—Mrs. Ralph H. Chaney, Augusta
 1939—Atlanta—Mrs. Warren A. Coleman, Eastman
 1940—Savannah—Mrs. Eustace A. Allen, Atlanta
 1941—Macon—Mrs. H. G. Bannister, Ila
 1942—Augusta—Mrs. Lee Howard, Savannah
 1943—Atlanta—Mrs. J. Lon King, Macon
 1944—Savannah—Mrs. Olin S. Cofer, Atlanta
 1945—No Convention
 1946—Macon—Mrs. W. T. Randolph, Winder
 1947—Augusta—Mrs. W. Bruce Schaefer, Toccoa
 1948—Atlanta—Mrs. W. G. Elliott, Cuthbert
 1949—Savannah—Mrs. S. A. Anderson, Atlanta
 1950—Macon—Mrs. J. Harry Rogers, Atlanta
 1951—Augusta—Mrs. Lehman W. Williams, Savannah
 1952—Atlanta—Mrs. J. R. S. Mays, Macon
 1953—Savannah—Mrs. Ralph W. Fowler, Marietta
 1954—Macon—Mrs. Leo Smith, Waycross
 1955—Augusta—Mrs. Shelley C. Davis, Atlanta
 1956—Atlanta—Mrs. Robert C. Major, Augusta
 1957—Savannah—Mrs. Walker L. Curtis, College Park
 1958—Macon—Mrs. John L. Elliott, Savannah
 1959—Augusta—Mrs. Luther H. Wolff, Columbus
 1960—Columbus—Mrs. Remer Y. Clark, Marietta

Convention Committees

WOMAN'S AUXILIARY TO THE FULTON COUNTY MEDICAL SOCIETY

General Chairmen

Mrs. William A. Hopkins, Fulton, *Chairman*
 Mrs. Robert T. Klingbeil, Cobb, *Co-Chairman*
 Mrs. Fincher C. Powell, DeKalb, *Co-Chairman*

Credentials and Registration

Mrs. William A. Smith, *Chairman*
Mrs. John B. Cross, *Co-Chairman*

Executive Board Meetings

Mrs. Walker L. Curtis (Pre-Convention)
Mrs. Shelley C. Davis (Post-Convention)

General Meetings

Mrs. Edgar M. Dunstan

Flower Arrangements

Mrs. Jack C. Norris, *Chairman*
Mrs. B. L. Shackelford, *Co-Chairman*

Arrangements

Mrs. William A. Hopkins, *Chairman*
Mrs. Shelley C. Davis Mrs. Walker L. Curtis

Exhibit Room

Mrs. F. William Dowda, *Chairman*

Hospitality

Mrs. Luther C. Clements, *Chairman*
Mrs. Louis S. Riccardi, *Co-Chairman*

Tellers

Mrs. Glenn A. Duncan, DeKalb County
Mrs. John M. Schreeder, DeKalb County

Timekeepers

Mrs. John Sandberg, Cobb County
Mrs. Donald Rooney, Cobb County

Information Booth

Mrs. Dan Y. Sage, *Chairman*

Fashion Show

Mrs. Robert T. Klingbeil, *Chairman*, Cobb County
Mrs. Howard M. Sigal, *Co-Chairman*, Cobb County

Luncheon

Mrs. Robert T. Klingbeil, *Chairman*, Cobb County
Mrs. Ralph W. Fowler, *Co-Chairman*, Cobb County

Pages

Mrs. Luther C. Clements, *Chairman*
Mrs. Jack J. Worth, Jr., *Co-Chairman*

Publicity

Mrs. Milton F. Bryant, *Chairman*

Past Presidents' Luncheon

Mrs. Remer Y. Clark, *Chairman*

Tea

Mrs. Fincher C. Powell, *Chairman*, DeKalb County
Mrs. William A. Smith, *Co-Chairman*, DeKalb County

Tour

Mrs. Fincher C. Powell, *Chairman*, DeKalb County
Mrs. Howard B. Lee, *Co-Chairman*, DeKalb County

Hostesses

Mrs. Luther C. Rollins, *Chairman*

Tickets

Mrs. John R. McCain, *Chairman*
Mrs. Ray G. Duncan, Cobb County
Mrs. Frank E. Morgan, Jr., DeKalb County

Memorial

Mrs. Walker L. Curtis Mrs. Mason I. Lowance
Mrs. Thomas N. Guffin Mrs. Worth Hobby
Mrs. William A. Hopkins

Transportation

Mrs. Jeff L. Richardson, *Chairman*

Pledge of Loyalty to the

Woman's Auxiliary to the Medical Association of Georgia

I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of Georgia. I will support its activities, protect its reputation, and ever sustain its high ideals.

Collect

"Keep us, O God, from pettiness; let us be large in thought, word and deed. Let us be done with fault-finding, and leave off self-seeking. May we put away pretense, and meet each other face to face, without self-pity and without prejudice.

May we never be hasty in judgment, and always generous. Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straight-forward and unafraid. Grant that we may realize it is the little things that create differences; but in the big things of life we are one.

And, may we strive to reach and to know the great, common woman's heart of us all, and O, Lord God, let us not forget to be kind."

The Program

SUNDAY, MAY 7

11:00 Registration
to *Empire Foyer, Biltmore Hotel*
5:00

Hospitality

Empire Foyer, Biltmore Hotel

**1:00 Pre-Convention Executive Board
Meeting—Dutch Luncheon**

(For 1960-61 officers, state chairmen,
district councilors, county presidents,
county presidents-elect, past state pres-
idents, and councilor to SMA Auxiliary)

Rooms 1007-1008-1009, Biltmore Hotel

PRESIDING

Mrs. W. P. Rhyne, Albany, President

INVOCATION

Mrs. Ennis W. Waldemayer, Americus

PLEDGE OF LOYALTY AND COLLECT

Mrs. Norman P. Gardner, Thomaston

**5:00 Joint Meeting—MAG House of
Delegates and Woman's Auxiliary**

Main Meeting Room

PRESIDING

Thomas W. Goodwin, M.D., Augusta,
Speaker of the House

ORDER OF BUSINESS (*See MAG Delegate's Handbook*)

REPORT OF PRESIDENT WOMAN'S AUXILIARY TO MAG

Mrs. W. P. Rhyne, Albany
YOUR AMA—1961

Leonard W. Larson, M.D., Bismarck, N. D.,
President, American Medical Association

MONDAY, MAY 8

8:30 Registration
to *Empire Foyer, Biltmore Hotel*
3:30

Hospitality
Empire Foyer, Biltmore Hotel

9:30 General Meeting
Empire Room, Biltmore Hotel
CALL TO ORDER

Mrs. W. P. Rhyne, Albany, President
INVOCATION

Mrs. J. N. Brawner, Sr., Atlanta
PLEDGE OF LOYALTY AND COLLECT

Mrs. Oscar H. Lott, Savannah
ADDRESS OF WELCOME

Mrs. William A. Hopkins, Atlanta, President,
Woman's Auxiliary to the Fulton County
Medical Society
RESPONSE TO WELCOME

Mrs. Rudolph W. Jones, Macon
INTRODUCTION OF HONOR GUESTS AND PAST
STATE PRESIDENTS

Mrs. Ralph H. Chaney, Augusta
PRESENTATION OF CONVENTION PLANS

Mrs. William A. Hopkins, Atlanta,
General Chairman
INTRODUCTION OF PAGES FOR THE DAY

Mrs. Luther C. Clements, Atlanta,
Hospitality Chairman
REPORT OF ADVISORY COMMITTEE TO THE
WOMAN'S AUXILIARY TO THE MAG

Virgil B. Williams, M.D., Griffin, Chairman
GREETINGS

Milford B. Hatcher, M.D., Macon,
President, MAG
Fred H. Simonton, M.D., Chickamauga,
President-Elect, MAG

INTRODUCTION OF GUEST SPEAKER
Mrs. Louie H. Griffin, Claxton, Councilor,
Woman's Auxiliary to the Southern
Medical Association

ADDRESS
Mrs. K. W. Howard, Portsmouth, Va.,
President, Woman's Auxiliary to the
Southern Medical Association

Business Session

CONVENTION RULES OF ORDER

Mrs. Shelly C. Davis, Atlanta,
Parliamentarian

ROLL CALL

MINUTES

Mrs. Louie H. Griffin, Claxton, Secretary
REPORTS:

President

Mrs. W. P. Rhyne, Albany
President-Elect

Mrs. A. Worth Hobby, Atlanta
Treasurer (*Including Auditor's report*)

Mrs. George M. Hutto, Columbus

ADDENDUM REPORTS:

Complete Reports (*As given in 1960-61
Annual Report Book*)

Recommendations from the Executive
Board Revisions

Mrs. C. James Roper, Jasper, Chairman
Report of Credential Committee

Mrs. William A. Smith, Atlanta

ANNOUNCEMENTS

MEMORIAL SERVICE

Mrs. Walker L. Curtis, College Park
RECESS OF SESSION

12:30 Dutch Luncheon
(**For past presidents of Woman's Auxiliary
to the MAG**)
Capital City Club, 7 Harris St., N.W.
PRESIDING

Mrs. Remer Y. Clark, Marietta,
Immediate Past President

2:00 Tour of Beautiful Atlanta Homes
to (transportation available, front of Biltmore
5:00 Hotel)

Tea and Reception
Coach House, 1280 Peachtree St., N.E.
RECEIVING AT TEA

Mrs. William A. Hopkins, Atlanta, General
Chairman and President, Woman's
Auxiliary to the Fulton County
Medical Society

Mrs. W. P. Rhyne, Albany, President,
Woman's Auxiliary to the MAG
Mrs. William MacKersie, Detroit, Mich.,
President, Woman's Auxiliary to AMA
Mrs. K. W. Howard, Portsmouth, Va.,
President, Woman's Auxiliary
to the SMA

Mrs. A. Worth Hobby, Atlanta, President-
Elect, Woman's Auxiliary to the MAG
Mrs. Milford B. Hatcher, Macon,
Wife of MAG President

Mrs. Fred H. Simonton, Chickamauga,
Wife of MAG President-Elect
Mrs. Robert T. Klingbeil, Marietta,
Co-Chairman of Convention
Mrs. Fincher C. Powell, Avondale Estates,
Co-Chairman of Convention

TUESDAY, MAY 9

9:00 Registration

to *Empire Foyer, Biltmore Hotel*

12:30

Hospitality

Empire Foyer, Biltmore Hotel

9:30 Continued General Meeting

Empire Room, Biltmore Hotel

CALL TO ORDER

Mrs. W. P. Rhyne, Albany, President
INVOCATION

Mrs. Ennis W. Waldemayer, Americus
PLEDGE OF LOYALTY AND COLLECT

Mrs. S. Anderson Roddenbery, Columbus
INTRODUCTION OF PAGES FOR THE DAY

Mrs. Luther C. Clements, Atlanta,
Hospitality Chairman
ANNOUNCEMENTS OF CONVENTION PLANS

Mrs. William A. Hopkins, Atlanta,
General Chairman

INTRODUCTION OF GUEST SPEAKER

Mrs. Leo Smith, Waycross, National
Chairman of Legislation, Woman's
Auxiliary to the AMA

ADDRESS

Mrs. William Mackersie, Detroit, Mich.,
President, Woman's Auxiliary to the AMA

Business Session

ROLL CALL AND MINUTES

Mrs. Louie H. Griffin, Claxton, Secretary
REPORT OF REVISIONS COMMITTEE

Mrs. C. James Roper, Jasper, Chairman
REPORT OF BUDGET AND FINANCE COM-
MITTEE

Mrs. John A. Meier, Albany
REPORT OF RESOLUTIONS COMMITTEE

Mrs. Robert Waller, Albany
REPORT OF CREDENTIALS COMMITTEE

Mrs. William A. Smith, Atlanta
REPORT OF COURTESY COMMITTEE

Mrs. Bruce Threatte, Columbus
REPORT OF AWARD COMMITTEES:
Achievement

Mrs. E. M. Dunstan, Atlanta, Chairman
Civil Defense

Mrs. F. Kells Boland, Jr., Atlanta,
Chairman
Doctor's Day

Mrs. Floyd R. Sanders, Decatur,
Chairman

Mrs. J. Boner White Scrapbook
Mrs. D. L. Head, Jr., Thomaston,
Chairman

Safety

Mrs. F. H. Thompson, Americus,
Chairman
Brawner Trophy for General Excellence

Mrs. Remer Y. Clark, Marietta, Chairman
REPORT OF NOMINATING COMMITTEE

Mrs. John L. Elliott, Savannah, Chairman
ELECTION OF OFFICERS
INSTALLATION OF OFFICERS

Mrs. Shelly C. Davis, Atlanta
PRESENTATION OF PRESIDENT'S PIN AND
GAVEL

Mrs. W. P. Rhyne, Albany,
Retiring President
INAUGURAL ADDRESS AND ANNOUNCEMENT
OF 1961-62 CHAIRMANSIPS
PRESENTATION OF PAST PRESIDENT'S PIN
Mrs. Remer Y. Clark, Marietta
ANNOUNCEMENTS
ADJOURNMENT

1:00 Luncheon and Fashion Show

(For all Auxiliary Convention Members)
(Fashion Show by J. P. Allen Co.)

*Cherokee Town Club, 155 Paces Ferry Rd.,
N.W.*

PRESIDING

Mrs. W. P. Rhyne, Albany,
Retiring President

WEDNESDAY, MAY 10

9:00 Post-Convention Executive Board

Meeting—Dutch Breakfast

(For 1961-62 officers, chairmen, district
councilors, county presidents, county presi-
dents-elect, past presidents, and councilor
to SMA)

Rooms 1007-1008-1009, Biltmore Hotel

PRESIDING

Mrs. A. Worth Hobby, Atlanta, President

11:00 Joint General Business Session

(All MAG and Auxiliary Members and
Guests)

Main Meeting Room

PRESIDING

Milford B. Hatcher, M.D., Macon, President
PRESENTATION OF 50-YEAR CERTIFICATES
Luther H. Wolff, M.D., Columbus, Immediate
Past President, MAG

PRESENTATION OF SCIENTIFIC EXHIBIT
AWARDS

Ted F. Leigh, M.D., Atlanta, Chairman,
Scientific Awards Committee
PRESENTATION OF GENERAL PRACTITIONER
OF THE YEAR AWARD

Joseph B. Mercer, M.D., Brunswick,
President, GAGP
PRESENTATION OF MAG CERTIFICATES OF
APPRECIATION

John T. Mauldin, M.D., Atlanta, Secretary,
MAG

PRESENTATION OF HARDMAN AWARD

Fred H. Simonton, M.D., Chickamauga,
President-Elect, MAG

**PRESENTATION OF MAG DISTINGUISHED
SERVICE AWARD**

Milford B. Hatcher, M.D., Macon, President,
MAGA

**SELECTION OF SITE FOR ANNUAL MEETING
1962**

**ANNOUNCEMENT OF MAG ELECTION RE-
SULTS**

Chairman, Tellers Committee

INSTALLATION OF 1961-1962 OFFICERS

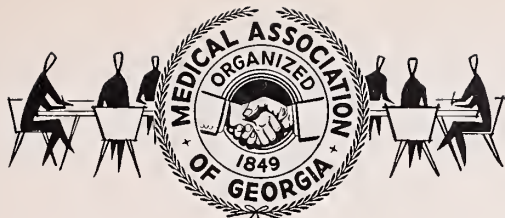
Milford B. Hatcher, M.D., Macon,
Immediate Past President, MAG

ADJOURNMENT OF 36TH ANNUAL MEETING

**NOTE: Tickets are available at Ticket Desk for Auxiliary Convention Members for the Tour and Tea on Monday and the Luncheon and Fashion Show on Tuesday.
Register at Ticket Desk for transportation.**

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
 2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
 3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
 4. Badges must be worn by members of the voting body during all general sessions of the convention.
 5. Delegates' privileges are not transferable.
 6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by the persons making and seconding the motion.
 7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
 8. All persons appearing on the program must be seated near the platform when the session opens.
- Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.



the association

MEDICARE DEPARTMENT

Washington Visit

The Georgia Medicare office was honored by a visit from Brigadier General Floyd Wergeland, Executive Director and Lt. Colonel George L. Grow, Executive Officer from the Office for Dependents' Medical Care in Washington during January. This was another in a series of routine visits implemented by the Washington Office to afford a closer working relationship between the various medical associations and societies over the United States and the Office for Dependents' Medical Care in Washington. These visits have in the past proved most beneficial to all concerned and in effect have promoted a more personal relationship between the Georgia office and the Headquarters office in Washington. General Wergeland stressed the point that he wished to encourage all doctors in Georgia to support Medicare and to benefit from the program.

New Manuals

MAG Medicare Manual 03161 (Light Blue Cover) have been printed and are available to all doctors who request them. This new manual is up to date in its provisions and also contains the maximum allowance for procedure codes used in the program. However, it is urged that doctors continue to charge on the Medicare claim form in accordance with the provisions stating: "It is expected that physicians will bill the Government their normal charges for persons with incomes of \$4,500. Such charges will be payable up to the maximum fee negotiated with the Government. The amount paid by the Government must be accepted as full payment for the allowable services rendered."

New Claim Form

According to the Office for Dependents' Medical Care in Washington, a new Medicare claim form will be available for use in the program April 1, 1961. This claim form will be much simplified and requires much less written documentation as opposed to the form now in use. New forms will be supplied physicians upon request as soon as they are made available to the Medicare office.

Proposed Maximum Allowance Changes

- (1) Cost of Drugs—A proposal to make a change

in the maximum allowance for drugs was rejected by the Office for Dependents' Medical Care for the following reason: "Physicians' fees for services include the administrative cost of maintaining his office. Therefore, the additional amount which has been authorized for parenterally administered drugs is the cost of the drug only."

- (2) Newborn Care in a Hospital Rendered by the Delivering Physician—A proposal to allow the delivering physician to charge a maximum equal to that allowed pediatricians was rejected by the Office for Dependents' Medical Care for the following reason: "The fee negotiated for newborn care was to compensate physicians specializing in the care of children for their care of the newborn."

DEATHS

W. A. ARNOLD died January 9 at his home in Atlanta at the age of 79.

A native of Franklin County, Dr. Arnold was a graduate of the old Southern Medical College which is now the Emory University School of Medicine. He did post-graduate work at the Mayo Clinic.

Recently the Fulton County Medical Society awarded him the Certificate of Distinction for 50 years in the practice of medicine. Dr. Arnold was also a member of the Medical Association of Georgia and was company surgeon for Southern Railway for over 40 years.

Survivors include his wife; a son, W. H. Arnold, Atlanta; five sisters, Mrs. J. W. Ward, White Plains; Mrs. G. W. Wright, Maysville; Mrs. Oscar Fuller, College Park; Mrs. B. B. Moon and Mrs. T. P. Jackson, both of Atlanta; two brothers, Lowery H. Arnold and J. Ralph Arnold, Atlanta, and two grandchildren.

WILLIAM P. MARTIN, 43, of Summerville, died suddenly January 10.

A native of Chickamauga, he was a graduate of the University of Chattanooga, the Medical College of Georgia, and interned at Macon Hospital.

During World War II, Dr. Martin served as a lieutenant colonel in the U. S. Air Force.

Dr. Martin, who had been a practicing physician in

Summerville for many years, was a member and deacon of the Summerville Presbyterian Church.

Survivors include his wife, the former Beth Mosheim, of Chickamauga; a daughter, Miss Beth Martin; two sons, William P. Martin, Jr. and J. E. B. Martin, all of Summerville; a sister, Mrs. Sarah Martin Harris, Chickamauga, and a brother, Duke Martin, of Los Angeles, Calif.

GEORGE L. MITCHELL, 42 widely known Decatur physician, died unexpectedly January 23 in Pensacola, Fla.

Born in Atlanta, he was graduated from the Emory University School of Medicine and did heart research at Grady Memorial Hospital before establishing his practice in Decatur.

He was a member of the Inman Park Baptist Church, the American Board of Internal Medicine, the American College of Physicians and Surgeons, and Sigma Chi social fraternity.

Surviving are his widow, the former Louise Stubbs; four sons, George L. Mitchell, Jr., Clyde Mitchell, John Mitchell, and Sam Mitchell, all of Decatur; a daughter, Miss Mary Mitchell, Atlanta; his mother, Mrs. G. L. Mitchell, Sr., Atlanta; two brothers, Ray Mitchell, Atlanta and J. H. Mitchell, Charlotte, N. C., and five sisters, Miss Julian Mitchell, Mrs. R. A. Harbort, and Mrs. C. B. Hackney, Atlanta; Mrs. John Potts, Charleston, S. C., and Mrs. Eugene Stennett, Memphis, Tenn.

B. O. QUILLIAN, of Douglas, died January 17 in a local hospital at the age of 77.

Dr. Quillian was graduated from the Atlanta School of Medicine and began Practice in Willacoochee. He moved to Douglas in 1930 and since that time he had been practicing medicine there.

A native of Banks County, Dr. Quillian was a member of the First Methodist Church, Masons, and the local and state medical associations.

Survivors include three sons, B. O. Quillian, Jr., Chamblee, Dr. Jesse Quillian, of Chattanooga, Tenn., and Edgar Quillian, of Atlanta; one brother, William C. Quillian, Phoenix, Ariz.; two sisters, Mrs. J. B. Thrasher, Douglas and Mrs. Annette Yarbrough, Atlanta, and seven grandchildren.

SOCIETIES

The BALDWIN COUNTY MEDICAL SOCIETY has entered into joint sponsorship with the Baldwin County Heart Council of a stroke rehabilitation program to serve Baldwin and surrounding counties. This clinic is held on the first and third Wednesday of each

month at 1 P.M. in the basement of the Baldwin County Hospital.

Dr. Richard Te Linde, well known gynecologist and author, from Johns Hopkins University, spoke to the BIBB COUNTY MEDICAL SOCIETY at the society's annual Witman Lecture held at the Pinebrook Inn in February. His topic was "Present Day Management of the Various Stages of Carcinoma of the Cervix."

The Woman's Auxiliary to the Cobb County Medical Society entertained the members of the COBB COUNTY MEDICAL SOCIETY in January at the Marietta Country Club.

New officers of the DEKALB COUNTY MEDICAL SOCIETY installed recently at the group's installation dinner are: Henry G. Carter, president-elect; Leslie C. Buchanan, president; Robert I. Gibbs, Jr., vice president; James E. Anthony, secretary-treasurer, and Hobson M. Rice, corresponding secretary.

An impressive memorial program commemorating the late Dr. H. M. McKemie was held in January at the regular meeting of the DOUGHERTY COUNTY MEDICAL SOCIETY.

The regular meeting of the GEORGIA MEDICAL SOCIETY was held in February, with Dr. George Miller, Professor of Urology at the University of Florida, speaking on "Non-surgical Treatment of Calculus."

A film explaining the mouth-to-mouth method of artificial respiration has been shown to 20 organizations in Brunswick and remains available to groups there. The film, purchased with money from the Brunswick Hospital trust fund, is administered by the GLYNN COUNTY MEDICAL SOCIETY.

The regular January meeting of the JEFFERSON COUNTY MEDICAL SOCIETY was held at the Jefferson Hotel, in Louisville.

The regular bi-monthly meeting of the SOUTHWEST GEORGIA MEDICAL SOCIETY was held recently in Fort Gaines. A lantern slide lecture on pathological specimens was presented.

The regular meeting of the SUMTER COUNTY MEDICAL SOCIETY was held in January at the Americus and Sumter County Hospital. Fred Thompson presented slides and statistics on Pap smears and follow-up tissues.

PERSONALS

First District

Memorial Hospital in Savannah has named J. H. PINHOLSTER, Savannah, chief of staff. Other top appointments were J. L. ALEXANDER, vice president and J. MOULTRIE LEE, secretary-treasurer, both of Savannah.

J. KIRK TRAIN, JR., Savannah, has become president of the professional staff of St. Joseph's Hospital for 1961.

Second District

The 1961 officers of the Tift County Hospital medical staff are: CHARLES ZIMMERMAN, president;

TOM L. EDMONDSON, vice president; and HENRY K. JARRETT, JR., secretary-treasurer, all of Tifton.

Recently the medical staff of Memorial Hospital in Bainbridge met for annual election of officers. At this meeting E. ASHBY WOODS, was elected chief of staff; FRANK L. GIBSON, was elected vice chief of staff, and J. WALTER SMITH was elected secretary.

Third District

BON M. DURHAM, Americus, was recently guest speaker at the meeting of the Americus Jaycettes. Dr. Durham showed slides on his visits to Europe.

The new chief of staff at Houston County Hospital is WILLIAM G. TALBERT, JR., Warner Robins.

Some 30 or more people from various sections in Muscogee County attended the health training meet held in Columbus recently and heard SIMONE BROCATO, Columbus, speak on causes of heart disease.

A. J. KRAVTIN, Columbus, addressed members of the Muscogee County P.T.A. Council recently at St. Elmo School auditorium on the subject "Young Marriages and Our Georgia Marriage Laws."

LUTHER H. WOLFF, Columbus, was recently elected vice president of Blue Shield as the Georgia Physicians Service held its annual meeting at the Columbus Country Club. At the same time GEORGE P. SCHUESSLER, Columbus, was elected secretary.

Fourth District

The American College of Surgeons met in Mexico in January and J. MORGAN KELLUM, Thomaston, attended.

J. RENDER TURNER, LaGrange, spoke to members of the Big Springs Community Improvement Club recently at the regular monthly meeting which was held in the recreation room of the Big Springs Methodist Church. Dr. Turner spoke on the care and cure of tubercular patients and conducted an interesting discussion of symptoms of the disease.

H. HILT HAMMETT, JR., LaGrange, was re-elected to the presidency of Blue Shield as the Georgia Physicians Service held its annual meeting at the Columbus Country Club.

Fifth District

The Decatur PTA council sponsored a joint meeting of all PTA's in the city, which took the place of the individual meetings at each school for the month of January. HENRY J. CLIMO, Atlanta, was guest speaker and chose for his topic "Youth Needs Parents."

"Open heart surgery," a modern miracle of medical science, was illustrated at public meetings in Waycross recently, launching the February Heart Fund campaign. RICHARD E. KING, Atlanta, was the speaker at a meeting held at the Waycross High School Auditorium.

ALFRED J. ASELMAYER, Atlanta, has been named director of Tuberculosis Control Service for the Georgia Department of Public Health.

Sixth District

Chief of staff at the Macon Hospital for 1961 will be J. P. WOODHALL, with JOHN P. JONES, as vice chief of staff, and OSCAR S. SPIVEY, secretary, all of Macon.

JAMES E. BAUGH, of Milledgeville, recently spoke to the Thomasville Kiwanis Club about his experiences and observations during his visit to Russia.

As the newly elected president of the Washington County Medical Society, WILLIAM S. HELTON, Sandersville, has also been named president of the Memorial Hospital in Sandersville. Also on the hospital staff will be MARION W. HURT, vice president and JOSEPH E. LEVER, secretary, both of Sandersville.

WILLIAM E. POUND, Macon, has been elected chairman of the Macon-Bibb County Board of Health.

For their work in the stroke clinic in Baldwin County, CHARLES B. FULGHUM and ZEB BURRELL, of Milledgeville, were recently honored by the Jaycees of Milledgeville at their Bosses Night.

THOMAS L. ROSS, Macon, was the featured speaker at a recent luncheon meeting of the Macon Kiwanis Club. His topic was "Heart Ailments and Their Varied Effects and Treatment."

W. T. SMITH, assistant chief of psychiatric services at Milledgeville State Hospital, recently addressed the study group of the First Methodist Church at Wrightsville on the subject "The Relation of Alcoholism to Mental Illness."

Seventh District

CHARLES K. RICHARDS, Calhoun, recently assumed duties as chief of the Gordon County Hospital medical staff. The other officer elected to serve with him is BYRON A. STEELE, Fairmount, vice chief of staff.

At a recent meeting of the Floyd County Medical Auxiliary, JAMES M. KELLY, of Rome, was guest speaker, discussing arthritis.

The newly elected officers of the medical staff of John L. Hutcheson Memorial Tri-County Hospital, Fort Oglethorpe for the year 1961 are as follows: ROY POPE, JR., Chickamauga, chief of staff; T. W. ALSO-BROOK, Rossville, assistant chief of staff, and ROBERT T. JONES, Lafayette, secretary.

Eighth District

Open heart surgery was illustrated at public meetings recently in Waycross and O. C. WYNN, Waycross, conducted the program held at Bailey Street Elementary School.

The Glynn County Board of Health announced recently the appointment of HART S. ODOM, formerly of Lafayette, as public health commissioner of District 4, comprising Glynn, Camden, McIntosh, Brantley, and Charlton counties, with headquarters in Brunswick.

The program of the Glynn County Heart Association was brought to the attention of the Brunswick Pilot Club recently at a dinner meeting. E. R. JENNINGS, Brunswick, guest speaker, discussed diseases of the heart and the work that is being done by the local heart group.

Ninth District

Recently HAMIL MURRAY, of Gainesville, attended and participated in the Medical Science Day held in Toccoa in January.

T. L. HODGES, JR., Clarkesville, discussed diseases of the heart and circulatory system when he addressed

the Cornelia Kiwanis Club at the community house in Cornelia the last of January.

Tenth District

MENARD IHNEN, of University Hospital, Augusta, recently presented Augusta Rotarians with a "tour" of a hospital laboratory using a series of slides.

State-supported higher education is at the crossroads in Georgia, Augusta Kiwanians were told recently, as HARRY B. O'REAR, president of the Medical College of Georgia, explained that more dollars for higher education are desperately needed to keep the University of Georgia System competitive with the systems and schools of southeastern states and the nation.

GORDON E. WALTERS, Augusta, has announced the opening of his office for the practice of internal medicine and cardiology at 1140½ Druid Park Ave.

FRANK MULLINS, of Augusta, recently attended and participated in a Medical Science Day held in Toccoa.

Having closed his office in Thomson, JOSEPH M. GARRISON has accepted a residency in anesthesia at Talmadge Memorial Hospital in Augusta. Although he will remain in Thomson, he will not practice medicine.

RAMON C. THOMPSON, Athens, has moved his office to 950 N. Milledge Ave.

CORRECTION

IN THE 1961 ROSTER of the *Journal of the Medical Association of Georgia*, the name of T. E. Rogers, Jr., 700 Spring Street, Macon, Ogb., was omitted. The *Journal* regrets this mistake and would appreciate everyone making this correction in his Roster.

Executive Committee of MAG Council Meeting Minutes

THE JANUARY MEETING of the Medical Association of Georgia Executive Committee of Council was called to order by Chairman Milford B. Hatcher at 10:15 A.M. on January 22, 1961 at the MAG Headquarters Building, Atlanta, Georgia.

The members of the Committee present were: Milford B. Hatcher, Macon, President and Chairman; Fred Simonton, Chickamauga, President-Elect; J. G. McDaniel, Atlanta, Chairman of Council; John T. Mauldin, Atlanta, Secretary, and Virgil B. Williams, Griffin, Chairman of Finance. Also present were Eustace A. Allen, Atlanta, AMA Delegate; John Venable, Atlanta, Director, State Department of Public Health; James W. Smith, Manchester; Jack W. Whitworth, Greenville, John S. Atwater, Atlanta; C. L. Ayers, Toccoa; S. U. Braly, Dallas; Mr. Milton D. Krueger, Executive Secretary; Mr. John F. Kiser, Associate Executive Secretary, and Mrs. Catherine Wooten, Executive Assistant.

Chairman Hatcher called on Mr. Krueger to read the minutes of the Council and Executive Committee of Council meeting of

December 11, 1960. There being no corrections, on motion duly made and seconded, the minutes were approved as read.

State Pre-Employment Physical Examination Recommendations

Mr. Krueger stated it was Dr. Peterson's desire to see Lester Petrie, Atlanta, State Department of Health, and discuss this matter further. The Executive Committee recommended that Dr. Peterson arrange an appointment with Dr. Petrie and Dr. Venable on the pre-employment physical and report to the February Executive Committee meeting.

Workmen's Compensation Negotiation Report

Mr. Krueger stated that Dr. Peterson would be unable to give a report at this time, but would like this item on the February agenda and it was so deferred.

White House Conference on Aging Report

John S. Atwater gave a report on this conference and Eustace Allen gave additional information. It was recommended that the members attending the conference be commended for their actions.

Relative Value Study Committee

Dr. Hatcher asked Executive Committee to consider certain recommendations and it was recommended that the Committee be composed of three to five members with an advisor from each District. Dr. Hatcher is to give complete information at a later date.

Finance Report

Mr. Krueger gave this report.

(a) *Format of 1961 Budget Reports*: Adopted with changes noted: It was suggested that the Contingent Fund be changed to show "Interest on Mortgage" and "Payment on Mortgage" and the Depreciation Fund is to be included under Liquid Funds available.

(b) *Final Statement 1960 Income and Expenditures*: The balance of 1960 is to be deposited in Savings and Loan savings account for further disposition.

(c) *Treasurer's Duties*: There was general discussion of the Treasurer's duties. On motion duly made and seconded it was voted to have the President write Dr. Arp regarding the following: (1) preparing a monthly statement for Executive Committee and Council to report on income and expenditures; (2) treasurer to present this monthly report to Executive Committee and Council and (3) report on investment program of MAG funds.

(d) *Mortgage Payment*: Referred until February meeting.

(e) *Medical Examining Board Unauthorized Medical Practice Cases*: Deferred until February meeting.

(f) *Investment of MAG Funds*: Discussed with no action.

Training Program for Medical Secretaries

Secretary Mauldin gave the report on the proposed program to establish schools for training of this type of personnel. On motion (McDaniel - Williams) it was voted to approve the idea in principle and recommended referral to the Hospital Relations Committee for working out final details and report back to Council for final approval.

AMA National Legislative Program

Dr. Hatcher read a letter from Dr. Vincent Askey. It was recommended that he write a letter of acknowledgement assuring Dr. Askey of MAG cooperation.

MAG Legislative Committee Recommendations

The bills before the Legislature, which had been discussed at the recent Legislative Committee meeting, were brought before the Executive Committee for recommendation. Mr. Kiser read and explained these to the Committee.

(a) *Blood Test Repeal Act*: Dr. Venable gave the Committee information on the pre-marital examination problems re: laboratory reports. He asked if the Committee would recommend repeal. It was the general opinion that this law should not be repealed but a more strenuous effort be made to get good results from blood tests and to do a more thorough physical examination. On motion duly made and seconded it was voted to oppose this proposal at this time.

(b) *Family Responsibility Bill*: On motion duly made and seconded it was voted to instruct legal counsel to get "no medical care charge" back into the proposed bill and to work with the State Medical Board regarding further study and submit a report to the Executive Committee.

(c) *Sterilization*: This was discussed by Dr. Venable. It was recommended that this be referred to the Legislative Committee to

be worked out with the Mental Health Committee and report back to the Executive Committee.

(d) *MAA Act*: On motion duly made and seconded it was voted that this bill be accepted in principle.

(e) *Advisory Council Bill*: On motion duly made and seconded it was voted that this bill be accepted in principle.

(f) *Senate Bill 33 and 52*: This was received for information.

(g) *OAA Act (SB 52)*: It was recommended that Secretary Mauldin talk with Mr. John Moore, Attorney and Mr. Krueger, with power to act.

(h) *Vocational Rehabilitation Bill*: It was recommended that Secretary Mauldin talk with Mr. Moore and Mr. Krueger, with the power to act.

(i) *Mental Health Study Committee House Bill*: This was received for information.

(j) *Workmen's Compensation Bill (HB 46)*: This was received for information.

(k) *Proposed Resolution on Rules Committee of U. S. Congress (HR 54)*: On motion duly made and seconded it was voted to send a letter of approval to all representatives, senators, AMA, and Speaker of House.

(l) *Resolution (HB 63)*: Received for information. No action taken.

(m) *Georgia Drug and Cosmetic Act (HB 67)*: Recommended approval with exception as suggested by the Legislative Committee.

(n) *Massage Board Bill (HB 73)*: No action taken.

(o) *Appropriations Act (HB 90)*: On motion duly made and seconded it was voted to approve Section 48 (ee).

(p) *HB 140*: On motion duly made and seconded it was voted to refer to Secretary Mauldin, Mr. Moore, and Mr. Krueger for study and action necessary.

(q) *HB 152*: No position.

(r) *HB 183*: Motion duly made and seconded to refer this to Secretary Mauldin, Mr. Moore, and Mr. Krueger for study and necessary action.

(s) *Tax-exemption Bill*: Received for information and so approved.

(t) *Naturopathic Bill*: Approved. Refer to committee of our representatives.

(u) *Gracewood State School and Hospital Bill*: Approved.

(v) *Proposed Identification Law*: Approved.

(w) *Hospital Identification Law*: Approved.

(x) *Establishment and Operation of Eye Banks*: Referred to Secretary Mauldin, Mr. Moore, and Mr. Krueger for investigation.

Dr. Allen and Mr. Krueger discussed two proposed trips to Washington to see Senator Russell and Congressmen. It was recommended that the Legislative Committee work out details and dates as soon as possible.

AMA Regional Medicolegal Conference

Mr. Krueger asked for suggestions as to who should attend this conference. It was suggested that the St. Paul Insurance Company attorney be invited to attend at his own expense, but the final decision about attendance to be decided by President Hatcher.

Officers Plaque

Mr. Krueger showed diagrams of plaques and price lists. On motion duly made and seconded it was voted to allow Executive Committee to make further inquiries about prices locally.

National Foundation Scholarship Request

President Hatcher read a letter requesting three members to serve on a committee to set up this scholarship. On motion (Williams-Simonton) it was voted to disapprove this request and President Hatcher was asked to notify the National Foundation of this action.

Coweta County Society Emergency Call Request

Secretary Mauldin read a letter from the President of Coweta County Medical Society regarding the emergency call situation in Newnan. It was recommended that the Secretary get the information and send to Dr. Hatcher for answer to the Society.

Medicare Bond and Salary

On Motion (Simonton-Mauldin) it was voted to disapprove the escrow proposal in lieu of bond at this time. On motion (McDaniel-Simonton) it was voted to raise the salary of the Medicare Administrator effective February 1, 1961 as recommended.

Headquarters Office Correspondence

Secretary Mauldin informed the Executive Committee of:

(a) *Korea Letter of Appreciation for Coweta County Society*

Contribution: It was recommended that this letter be forwarded to Coweta County.

(b) *Auxiliary Letter of Appreciation for use of MAG Building*: Received for information.

(c) *Air Conditioning Contract*: Actual cost of maintenance in 1960 to be compiled and brought before March Executive Committee meeting for decision at that time as to whether contract will be purchased.

(d) *Unincorporated Associations*: It was recommended that the Secretary investigate this through MAG attorney.

Headquarters Office Report

Mr. Krueger gave this report for information. He discussed replacement for Mr. Kiser who is leaving MAG February 1, 1961.

Unfinished Business

(1) *AMA Rural Health Conference*: Attendance was disapproved.

(2) *School Child Health Committee Sports Conference*: Recommended that check (\$111.45) sent by Jack Hughston as money collected from persons attending the "Medical Aspects of Sports Conference" held in Columbus, August 1960, be deposited in 1960 general fund.

New Business

(1) *Georgia Association of Plaintiff Trial Attorneys Meeting*: On motion duly made and seconded it was voted to have the Secretary and Mr. Krueger work out the details of MAG participation at this meeting.

(2) *Buena Vista*—Report was received from President Hatcher regarding the reported hepatitis epidemic in Buena Vista. It was suggested that a letter be written to the Mayor, Chamber of Commerce, and Editor of the paper at Columbus to thank them for informing us of the situation.

(3) *Date and Site of February Executive Committee Meeting*: February 19, 1961, 10:30 A.M., MAG Headquarters, Atlanta.

(4) *Date and Site of March Council Meeting*: To be held in Atlanta, but time and date to be decided later.

There being no further business the Executive Committee of Council meeting was adjourned at 6:00 P.M.

DOCTOR SPENCER ATKINSON KIRKLAND

A Tribute

Jack C. Norris, M.D., Atlanta

DOCTOR SPENCER ATKINSON KIRKLAND, of Atlanta, died at his home, December 29, 1960. He was 71 years of age.

Kirk, as many of his friends called him, had specialized in urology. He was a pioneer in that field, and by virtue of his experience and ability, was widely recognized throughout the State of Georgia, including those of his friends in the American Medical Association, where he had served as Delegate from Georgia for two terms.

Doctor Kirkland was a graduate of Emory University, 1911, interned at Grady Hospital, later going to Miami, Florida, 1926, to engage in a year of general practice. He returned to Atlanta after postgraduate work in urology in New York. His active life in Atlanta enabled him also to give attention to other activities and in due time he became a member of the American Medical Association; Atlanta and Georgia Urological Societies; the Medical Association of Georgia; Fulton County Medical Society, and the International College of Surgeons. He was a former member of the State Board of Health and associate editor of the

Journal. In 1948 to 1954, he had served the State Committee on Legislation and was later cited for his contributive work on that body.

For many years, Doctor Kirkland had been a consultant surgeon to the Veterans Administration, Atlanta region, and during World War II, was a member of the Selective Service Board. He was a member of the Peachtree Road Methodist Church, Yaarab Shrine Temple, Capital City Club, American Legion, the Phi Chi Medical Fraternity, and the staff of local hospitals, being formerly the President of Crawford W. Long, Emory Division.

Doctor Kirkland was born in Pearson, Georgia, the son of Mr. and Mrs. Jeff Kirkland, who were very prominent citizens. Early in his life, Kirk left home to make his own way in life, going first to a junior college and to the Georgia Business School, eventually entering Emory University to study medicine. After his graduation, he became acquainted with Miss Nell Fielder, from Cedartown, also a member of a distinguished family. Kirk and Nell married, making their permanent home in Atlanta, where he practiced for 40 years. Their daughter, Virginia, is now Mrs. Robert Blackwood, the wife of a well known local attorney and has two sons. Kirk's brother, Doctor Paul Kirkland, is a widely respected Manchester physician.

Needless for me to say, Kirk's death was shocking. He was a person who had always radiated excellent health, a pleasing personality, seldom becoming upset or disturbed about anything. Only a few close friends had been informed of a heart ailment, followed by severe angina. Upon resting and good care, he improved, but the returning angina forced him to remain in bed. He naturally became discouraged. On the morning of his death, he seemed to be better. He suddenly collapsed, however, and passed away quickly before anything could be done to help him.

For the personal part of my tribute may I add most humbly, that I do believe I can say, beyond those of his immediate family, I knew as much as any other person about Kirk. Hardly a week passed without his coming into my office to see me. During those visits, we talked about everything of the past, the future, of our friends, our families, politics, and medical affairs. Thus it was so that we cordially swapped ideas. He was not much of an open talker, hesitating to express himself in public. I never recall him speaking ill of anyone.

Among Kirk's other delightful qualities was his humbleness. Furthermore, he had an innate ability to be tactful on almost all occasions. He knew when to come and when to leave, always careful not to put himself in any place where he should not be. He kept this spirit up until the last. Another admirable feature of his was that he never lost his interest either in his specialty or the medical profession, being a consistent attendant at medical meetings, seldom missing the Fulton County Medical Society, the A.M.A., nor the State. He rarely sought an office, and if elected to any, it was done by the urging support of friends, and in return he was ever ready to go to bat for those whom he thought merited an honor.

Kirk was a great lover of sports, including baseball, football, and especially hunting and fishing. When a younger man, he would spend as much time as he could in the field after birds, duck or deer. In recent years, fishing had been his greatest outside pleasure.

There is little else left for me to say about my friend, but I shall record what others have told me. One, who was associated with Kirk in his formative years, once said, "Kirkland is the most completely unselfish man I have ever known." What a grand tribute that was, and I know it was so. His former commanding officer in World War I, expressing his sadness over Spencer's death, stated, "Kirkland was one of the best, if not the best of soldiers and officers under my command, always standing out ready to do his duty; even more than that while under shell and fire, wherever treatment was needed on the battlefield."

We have other information to the effect that during the fighting in "no man's land," World War I, Kirk had been unable to shed either his shoes or clothing for nearly 30 days, constantly exposing himself to injury. Yet, as far as I know, he did not receive medals, probably never even suspecting that he had earned any. To my mind the term "hero" is one which he certainly deserves to also be remembered by.

His medical and lay friends, including many patients, who read this humble tribute, shall agree that we have lost a true friend; urology a pioneer; surgery and medicine, a strong support; the State and Atlanta, a good citizen; I, a devoted pal. Kirkland was not a physician who shall be remembered necessarily for his contributions to science, but as a man who will be thought of for many years to come, as a kindly, liberal, ethical, humble, southern physician, beloved by many; a doctor who well understood his responsibilities as a servant of the sick, trusted completely by both patients and his associates.

Certainly we shall miss him. For myself, the passing of a close friend such as he, is an irreparable loss. It will not be easy to look at the empty chair.

Doctor Kirkland has gone to a better world. During one of our last chats, he stated he was satisfied that God did exist; thus I am certain he had Hope and Comfort in his heart to support him while he faced the end. Such a spirit is more than sufficient to say: "Rest in peace, my friend; rest there forever more."

NEW MEDICARE MANUAL

(Light Blue Cover)

Available March 1, 1961 Upon Request

Up to Date

**Procedure Maximum
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938 Peachtree Street, N.E.

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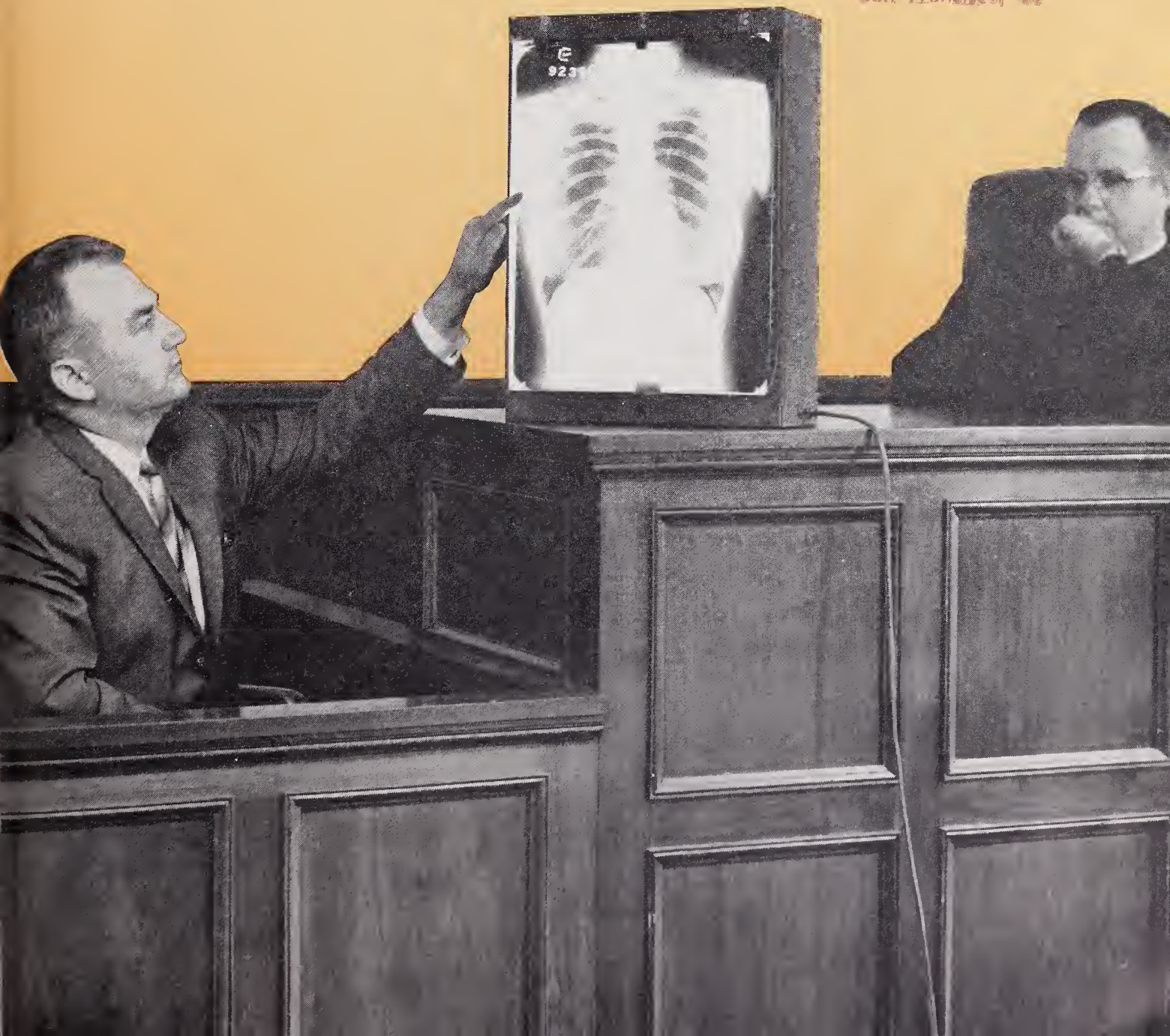
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FOUR-YEAR EXPERIENCE WITH FENESTRATION OF THE OVAL WINDOW

John J. Shea, M.D., *Memphis, Tennessee* and
Gosta Ewert, Med. Lic., *Stockholm, Sweden*

In many instances the postoperative air-conduction level is better than the preoperative bone-conduction average.

THE SURGICAL TREATMENT OF otosclerosis has been the subject of intense study and experimentation for the last 80 years.

Kessel¹ made the first report on mobilization of the stapes in 1876 and on stapedectomy in 1894 and after him these operations were done by otolaryngologists in Europe as well as the United States for more than 20 years. Notable among these were Boucheron,² Miot,³ and Jack.⁴ The middle ear was entered through the drum, either by a myringotomy or partial or total myringectomy, leaving the middle and sometimes the inner ear open postoperatively. It is surprising the results were as good as they were, such as those reported by Miot, who in 1890 claimed 74 per cent immediate fair results out of 126 cases, when it is recalled these operations were done without magnification or antibiotics.

The long-term results were, however, usually not good, and too many of these cases developed labyrinthitis and meningitis, the latter cases usually with fatal outcome. For this and other reasons the stapes operation was abandoned about 1900, after having been condemned by Politzer in 1893 and 1894 and Sibenmann in 1900.

After the direct approach to the oval window had failed other surgical methods were tried, and

the era of creating a bypass window into the labyrinthine cavity began. In 1892 Passow⁵ reported a case with hearing loss, tinnitus, and vertigo, in which a fenestra one-half millimeter in diameter was created at the edge of the ankylosed footplate, with temporary relief. Keeping this new fenestra open met with tremendous difficulties, and numerous modifications of the technique were tried by different surgeons. Among these should be mentioned Gunar Holmgren,⁶ who in 1922, together with Carl-Olaf Nylen, introduced the Gullstrand loupe, which is still being used by many operators today, and the binocular microscope. In the following years they introduced many modifications, such as fenestrating the superior semicircular canal in the middle cranial fossa, the promontory, and also the horizontal semicircular canal, in order to find a way to keep the fenestra open. Not until 1930, when Sourdille presented his multiple stage operation, were there any more successful reports. During the following years intense experimentation and refining of the method were made by Sourdille (1935 and 1937)⁷ and Holmgren (1931-36-39).⁶

One-Stage Fenestration

In 1938⁸ Julius Lempert could present a one-stage fenestration of the horizontal semicircular canal operation. Lempert, Shambaugh,⁹ and others later refined the technique of fenestrating the horizontal semicircular canal to its present high degree of perfection. This was the operation of choice for otosclerosis until 1953, and long-term results of 70-90 per cent of patients receiving serviceable hearing were reported uniformly from all over the world. The use of better surgical technique and powerful

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antibiotics almost eliminated the complication of infection. There were, however, two major disadvantages of this technique:

- (1) resulting air-borne gap of 20 to 30 decibels which remained following even the most successful surgery, because of abandoning the normal level-transformer action of the drum and ossicles and
- (2) remaining cavity that needed regular after-care in every case.

These drawbacks, and the introduction of an improved surgical microscope, naturally brought about a renewed interest in the direct approach to the otosclerotic focus in the oval window and stapes, which had been abandoned 50 years before. In 1952 Samuel Rosen accidentally rediscovered the long-forgotten technique of mobilization of the stapes. In the following years he and others have introduced various modifications of the technique. As in the case of fenestration of the horizontal semicircular canal, the long-term results with the mobilization operation were not as good as the immediate post-operative improvement, due to the inevitable re-fixation of the stapes.

By-passing Otosclerotic Focus

By-passing the otosclerotic focus, by making a fracture in the macroscopically normal part of the footplate and performing an anterior crurotomy operation, as advocated by Edmund P. Fowler, Jr. (1956) and Lennart Holmgren (1957), gave more lasting improvement, but this method was restricted to those cases where the lesion was confined to the anterior part of the footplate only. In those cases where the whole footplate and the oval window were invaded, little improvement could be expected by this method, and fenestration of the horizontal semicircular canal was still the only dependable method of restoring patients' hearing.

It was in May of 1956¹⁰ that I introduced the concept of fenestrating the oval window, by removing the stapes, and rebuilding the sound-conducting mechanism of the ear, by covering the fenestra with a membrane and replacing the removed stapes with an artificial implant. The first membrane used was a slice of subcutaneous tissue, and the first implant a plastic (teflon) replica of the stapes. Since 1957 I have been using a small piece of vein taken from the back of the patient's hand to cover the fenestra, and a length of polyethylene 90 tubing to rebuild the sound-conducting mechanism, fitting the tubing over the lenticular process of the incus, and resting the lower end of the tubing on the center of

the vein graft. This technique was reported in this country and in France in 1958.¹¹

Since that time many modifications of the basic technique of fenestration of the oval window and rebuilding the sound-conducting mechanism have been described. In 1958 Schuknecht reported using a piece of fat or connective tissue to cover the fenestra, to which was attached a short length of tantalum or stainless steel wire wrapped around the lower end of the incus, to rebuild the sound-conducting mechanism. Portmann in 1958 modified the technique in that after removing the stapes he used the vein to cover the fenestra and then replaced the entire stapes. He has called this technique "interposition" and has reported good results by this method. The published results by these and other methods cover only a few months usually, and the long-term results will have to be evaluated during the coming years, but theoretically one would expect that a hole as large as the oval window, particularly being a normal opening in the body, would have a much greater chance of remaining open than an unnatural opening made in the horizontal semicircular canal and other places even if the opening in the oval window is made through otosclerotic bone. The present trend is to remove the entire stapes, recreating the normal margins of the oval window with picks and a small drill, and then covering the fenestra with either a vein graft, as originally described, or fat or connective tissue as advocated by Schuknecht, or gelfoam as advocated by House and Sheehy. The lenticular process is then connected to the membrane over the oval window by one of the aforementioned methods.

Material

Since January 1, 1958, I have followed the technique of removing the entire footplate and rebuilding the sound-conducting mechanism by covering the fenestra with vein graft and the use of a polyethylene implant. For the total number of 150 cases operated on between October, 1958 and March, 1959 by this method, the 100 most recent consecutive cases, with one year follow-up audiograms taken in our clinic by the same audiometrist, have been selected for this analysis. Some of the remaining 50 cases have not returned here for their postoperative hearing tests and, therefore, are not included in this series. Not included also are: (1) one case of previous fenestration of the horizontal semicircular canal, (2) one case with a missing incus because of a previous radical mastoidectomy, and (3) two cases where the fenestra created were too small, one-half by one millimeter and one by one millimeter, respectively, to be considered representative of this technique.

Table 1 shows the cases according to Shambaugh. It also shows the proportion between men and

women and the average air-bone gap of the different groups.

TABLE I

Group	Women	Men	Sum	Average A-B Gap
A	33	24	57	36 db
B	20	15	35	32 db
C	5	0	5	27 db
D	2	1	3	32 db
Sum	60	40	100	

It is often surprising to notice the extent of the pathologic condition at the time of surgery when the mucosa of the promontory is dissected away from the oval window niche in order to prepare the bed for the vein graft. The otosclerotic area is usually much larger than one would expect from observing the pathology through the intact mucosa.

Results

We have chosen to report in analyzing our results the number of cases that have reached to within 10 decibels or less of the preoperative bone-conduction level as the criterion for success. Of the 100 patients that make up this report, 94 reached to within 10 decibels of the preoperative bone-conduction level after one year.

In many instances, the postoperative air-conduction level is better than the preoperative bone-conduction average. The reason for this phenomenon is still unknown, but the fact remains that opening the inner ear improves the bone-conduction curve some 10 decibels in many, but not all, cases. Only six out of 100 cases have failed to reach within 10 decibels of the preoperative bone-conduction level. The reason for choosing the air-bone gap of within 10 decibels of the preoperative bone-conduction level as the criterion for success is that eliminating the preoperative air-bone gap is theoretically, as well as practically, possible by the modern fenestration of the oval window surgery and, therefore, in this way we can minimize the differences between the American and European audiometric standards of five to 10 decibels which is so confusing when comparing the results of American and European operators.

Examination of the six failure cases is shown in Table 2.

TABLE II

Case	Group (Shambaugh)	Gain	Remaining Gap
741	B	25	20
775	A	25	15
842	A	10	15
912	A	5	20
943	C	10	15
1030	B	0	20

Case 741 closed the preoperative gap within 10 decibels three months postoperative but later drop-

ped; the air-bone became 20 decibels. In this case the otosclerotic focus was of the soft, active type, and only the posterior 40 per cent of the footplate was removed, which might be the reason for the failure in this case.

In case 775 only a small fenestra was created. Bony over-growth is probably the reason for the failure because the postoperative gap was 10 decibels three months following surgery, but one year after surgery had grown to 15 decibels.

Case 912 is interesting in that it is the only one of the 100 cases where the postoperative bone-conduction dropped from the preoperative average of 10 decibels to 30 decibels one year after surgery. This means that the postoperative air-bone gap is only five decibels, as the one year postoperative audiogram shows an average air-conduction level of 35 decibels. The reason for this drop is unknown. The patient has not complained of vertigo or tinnitus or other symptoms of inner ear injury, but discrimination in this ear is very bad, and for this reason this patient must be considered an operative failure.

Case 1030 has closed the air-bone one month after surgery, but on the following audiogram the gap was back at the preoperative level of 30 decibels; that is, no gain. It might have been that the polyethylene tubing had come loose, and for that reason this patient was scheduled for revision.

We have no explanation why the remaining two cases, 842 and 943, did not succeed.

This analysis shows that 94 cases out of 100, followed for one year after surgery for otosclerosis, have reached an average air-conduction level of within 10 decibels or less of the preoperative bone-conduction level. These results are in good accordance with Portmann's who with 40 cases in 1959 reported 95 per cent immediate good results, with 93 per cent maintaining the gain for six months, and 89 per cent for one year.

The evaluation of the long-term results is still to be made. Which procedure will give the best results, or what modification of the technique already used will improve the results even more, remains to be seen. Until now, however, our experience has been that the larger the fenestra created the more complete removal of the otosclerotic process accomplished, the better the chance for a lasting good result.

Complications

Only one loss of hearing in this group, and that for discrimination, although the air-conduction level improved from 40 to 35 decibels. Of the whole series of 1400 fenestration of the oval window cases, hearing loss of any degree is about one per cent, and serious hearing loss less than 0.5 per cent.

Important to stress in regard to these complications:

FOUR-YEAR EXPERIENCE / Shea

1. None occurred in a simple, uncomplicated operation, and most were in ears being operated upon for the second or third time.

2. Most were due to trauma at surgery, especially pushing the tubing in too deeply into the vestibule. Two in patients with prior fenestration of the lateral semicircular canal.

3. None in last six months due to greater caution about pushing tubing or vein into the oval window.

4. I never used chisels, hence less trauma to inner ear, but because of having done so many I have a large number of difficult cases referred to me by others to load my series against me.

Summary

The history of otosclerosis surgery and its road to the modern footplate procedure is shortly described. One hundred cases of one year results after fenestration of the oval window with vein graft and polyethylene implant by my original technique are presented. Ninety-four of the 100 cases reached within 10 decibels or less of the preoperative bone-conduction level. The six unsuccessful cases are briefly analyzed and some reason for their failure advanced.

22 North Pauline

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ANNUAL MEETING OF S.C. MEDICAL ASSOCIATION

THE 113TH ANNUAL MEETING of the South Carolina Medical Association will be held at the Francis Marion Hotel, Charleston, S. C., April 25-27.

The program will include the usual business meetings, beginning on April 25 and ending on the morning of April 26, and a scientific program which will be presented largely by members of the Faculty of the Medical School of the University of North Carolina, beginning in the afternoon of April 26. Speakers will be Dr. James F. Newsome, Dr. Herbert S. Harned, Dr. William B. Blythe, Dr. A. Stark Wolkoff, and Dr. Charles A. Bream. Speakers from South Carolina will include Drs. Frank F. Espey of Greenville, Peter Gazes and Wendell Thrower, both of Charleston. The visiting speakers will join a number of members of the Association in pre-

sentation of panels on thyroid diseases, effects of drugs and anesthetic agents on mother and child, collagen diseases, and painful female pelvis. Members of the Association will also offer discussion of the subject presented by the guest speakers.

Subjects to be discussed by the various speakers include head injuries, peptic ulcer, acute coronary insufficiency, non-opaque foreign body bronchiectasis, jaundice, breast malignancy, physiologic changes at birth, acute renal insufficiency, bleeding in pregnancy, and roentgenotherapy in female malignancy.

The meeting will also include two banquets, a dance, and the President's breakfast.

The Woman's Auxiliary of the South Carolina Medical Association will hold its meeting at the same time.

THE FAT AND THE LEAN

Robert B. Greenblatt, M.D.; Edwin C. Jungck, M.D.;
John A. Lord, M.D., and H. Clayton Courson, M.D., *Augusta*

Motivation remains the key factor in weight normalization.

Let me have men about me that are fat;
Sleek-headed men and such as sleep o' nights;
Yon Cassius hath a lean and hungry look;
He thinks too much: such men are dangerous . . .
Would he were fatter!"

(Julius Caesar, Act 1, Scene 2)

Shakespeare's allusion to the fat and the lean in his classic play, "Julius Caesar," succinctly epitomized an opinion which appears to have been held by scholar and layman alike ever since man started to record his ideas in picture and word. The consensus of myth, legend, history,[®] and drama overwhelmingly equated obesity with good-naturedness, and leanness with shrewd, self-critical, calculating ruthlessness.

Throughout our formative years, we are exposed to "fat and jolly" Santa Claus, Old King Cole (a merry old soul), "Honest Jack" Falstaff, and Henry the Eighth (the Merry Monarch). A few decades ago, journalism came up with the misguided eponym, "Happy Herman," for stercorous and corpulent Goering, and more recently the press predicted a thaw in the cold war when overly stout Khrushchev replaced saturnine Stalin.

On the other side, the remarkable association of a lean stature with a spiritual loftiness is most striking (e.g. Jesus, Ghandi, Abraham Lincoln, Shelly, Mozart). A glimpse at one of the most popular works of fiction devoted to a lean villain contradicts the time entrenched doctrine. Scrooge is popularly accepted as a mean, cruel reprobate, yet much of his anger is against excesses rather than

persons, while practicing his own system of asceticism.

In the following sections on etiology and therapy of obesity and leanness, we present evidence to support this re-appraisal. Not only can 95 per cent of obesity be shown to be associated with maladjusted behavior patterns (occasionally aggravated by abnormalities of assimilation, storage, and utilization, or impaired fat mobilization), but the directed use of *motivation* is shown in these individuals to be the most powerful weapon which we have available for reversing the chronic disease pattern of habitually excessive caloric intake. Moreover, the intimate relationship between mechanisms leading to obesity and leanness, sometimes produced by one and the same pathological condition, has been brought out in our work and we illustrate this in Table 1.

Endocrine Obesity

It has been said that "the only gland to cause obesity is the salivary gland." This aphorism has done much to discourage the common practice of incriminating the endocrine system in exogenous obesity and diverting both patient and doctor from the real problem: reduction of excessive caloric intake. Of the small percentage of cases that are truly endocrine, hyperadrenalcorticoidism is the most striking. Cushing's syndrome is characterized by obesity (localized to the face, neck, and trunk to produce "moon faces" and "buffalo hump"), hypertension, plethora, weakness, osteoporosis, purple striae, demasculinization in males, pseudomasculinization in females, emotional disturbances, polycythemia, and decreased glucose tolerance.¹ A similar appearance may be seen following prolonged corticosteroid or ACTH therapy. The islet cell tumor of

From the Department of Endocrinology, Medical College of Georgia, Augusta, Georgia.

Supplies of phenylpropanolamine (RB119-A) and aspirin (RB110-A) used in this study were generously provided by Plough, Inc. The methandrostenolone was supplied as Dianabol® by Ciba Pharmaceutical Products, Inc.

TABLE 1

Types of Obesity	Types of Leanness
Endocrine (5%)	Endocrine
Hypocorticism (Cushing's syndrome)	Hypopituitary (Sheehan's syndrome, Simmonds' cachexia)
Hypothyroidism and myxedema	Hypoadrenal
Hypogonadism	Hypothyroid
Hypo-ovarianism	Hyperthyroid
Froehlich's syndrome	Hypogonadal
Hypothalamic type (Laurence-Moon-Biedl syndrome)	Diabetes mellitus
Islet cell tumor	Diabetes insipidus
Diabetes mellitus	
Non-Endocrine (95%)	Non-Endocrine
Over-eating	Caloric intake below average
Normal eating but increased fat storage and/or impaired fat mobilization	a. constitutional
Genetic	b. hereditary
	c. social (racial or economic)
	d. malabsorption (normal appetite but poor utilization, e.g. aged post g.i. surgery)
	e. geriatric (poor protein utilization)
	f. during and following acute and chronic infection (including latent foci of infection)
	g. in malignancy
	Output of nervous energy abnormally high so that metabolism is pitched higher
	Anorexia nervosa
All cases of obesity are a poor insurance risk.	Most cases of leanness are a good insurance risk (in the absence of serious etiological disease).

the pancreas may also be associated with obesity since the hyperinsulinism induces hypoglycemic symptoms which are relieved by overeating. Obesity due to hypogonadism may occur following male castration or in eunuchoid subjects.² In Froehlich's syndrome (adiposogenital dystrophy), there is concomitant hypopituitarism and a hypothalamic lesion. The role of the hypothalamus in obesity has been studied in animals where experimental lesions in the ventromedial nucleus produce hyperphagia causing weight gain. In humans, accidental or surgical trauma and tumors of the hypothalamic region may lead to obesity.

The tremendously widespread use of thyroid substances in obesity originates in the demonstration of low metabolic rates in these subjects. Although this test has been shown to be most inaccurate when performed in obese individuals, nevertheless the therapeutic agent remains in the armamentarium, frequently causing increased appetite while the patient is on thyroid medication and iatrogenic hypothyroidism when the patient goes off medication.^{2b}

Genetic Obesity

Though of great theoretical importance, the clinical insignificance of genetic obesity cannot be overstressed. The typical obese patient has already rationalized himself into this category, "My friend eats three times as much as I do and remains slim."

The very admission of its existence by a doctor may render an obese patient virtually incurable. The following entities may be considered examples of genetic obesity. The recessively inherited Laurence-Moon-Biedl syndrome consists of obesity, mental retardation, hypogenitalism, skull deformities, polydactyly, retinitis pigmentosa and congenital nystagmus.^{3a,b} In 1929, Christiansen⁴ described a condition that he called macrosomia adiposa congenita, including seven of the nine children of two sisters. These offspring were excessively obese and five died in the first year of life. The Morgagni-Stewart-Morel-Moore syndrome^{5a,b,c,d,e} consists of obesity, amenorrhea, hirsutism, psychoneurosis, weakness, hypertension, headaches, and radiologically dense cancellous bone on the inner table of the frontal bone. In von Gierke's disease, general or local obesity in childhood accompanies hepatomegaly, hypoglycemia episodes, dwarfism, ketonuria, lipemia, and a diabetic type glucose tolerance curve. Faulty glycogenolysis is thought to be the underlying disorder in von Gierke's disease.⁶

Clinically, these are merely fascinating rarities, never to be mentioned to the average obese patient in whom the only hereditary factor involved is "the inheritance and perpetuation of an overloaded dinner table."

Psychological Obesity

Overeating is almost without exception a psychological sublimation or shield. Anxiety, dissatisfaction over intellectual, social or business affairs, and the reality of difficult situations may promote the consumption of more calories than all the supersubtleties ever conceived by the Cordon Bleu. The penchant is created at the ample parental board. Later, the caprice of the Dow-Jones averages or "the pangs of despised love" cast the already conditioned subject in his greatest role: the voluptuary of the dinner table. Yudkin⁷ states that the chances are 75 per cent that a child will be overweight if both parents are and only nine per cent if neither is.

Change from an active to a sedentary job without decrease of caloric intake is a common cause of obesity, as is the removal of a source of infection such as markedly infected tonsils in young individuals.

Therapy of Obesity

In the therapy of obesity, consideration is usually given to diet, exercise, sweat (turkish) baths, anorexic agents, and, at times, correction of hormonal imbalance. Without reduction of total caloric intake below energy expenditure, there can be no appreciable weight loss. Subject to this all-important quantitative proviso, various qualitative variations have their protagonists. Thorn and Bondy⁸ advocate a high protein, low calorie diet, so as to utilize the specific dynamic action of protein. Rynearson and

Gastineau⁹ have demonstrated a higher weight loss on a fat rich diet than with an isocaloric protein/carbohydrate diet. Bloom¹⁰ commences weight reduction with a period of fast; the resulting ketosis produces a sense of well being which aids the subject in adhering to a low calorie diet. In general, mild exercise aids reduction without stimulating appetite.

The benefits obtained by obese patients who frequent turkish baths, spas, and massage parlours probably result from the relaxed state induced in these establishments. The emotional tensions which were relieved by excessive eating are removed and food intake becomes normal.

Glandular therapy may be indicated in specific endocrine diseases of obesity. It should always be supervised by an expert. Earlier, we have condemned the indiscriminate use of thyroid without complete tests and called attention to its dangers (such as the production of iatrogenic hypothyroidism).

The main anorexogenic agents are sympathomimetic amines (amphetamine, phenylpropanolamine, methamphetamine, dextroamphetamine, and phenmetrazine). Unfortunately, their side effects (nervousness, insomnia, palpitations) and the rapid development of tolerance leave much to be desired and have led Rynearson to state, "anorexogenic drugs are of questionable value in the treatment of obesity."¹¹

These considerations led the authors to conduct clinical trials designed to assess the relative values of anorexic agents and *motivation* in weight reduction.

Experimental Double Blind Study Employing an Anorexic Agent and Aspirin

The method of procedure was as follows: Each patient was given a printed form entitled "Weight Reduction Plan." This form contained a short dissertation on the desirability of weight reduction in obesity and outlined how this goal might be attained. The text was so prepared as to arouse in the patient what the authors consider the most valuable weapon which the clinician has in his therapeutic armamentarium for this condition; namely, motivation. The text tried to unleash in a few words the most powerful driving forces which psychology and sociology have revealed. Allusion was made to improvement in physical appearance, longer life, better health (including specific mention of the higher incidence of diabetes, hypertension, arteriosclerosis, gall bladder disease, and hepatic cirrhosis in the obese). Excess caloric intake was bluntly given as the cause of obesity and reduction of this intake as the only solution. This blow was immediately softened by conceding that time would be required to reverse the chronic disease habit, a slow prolonged effort, in

fact, being considered preferable in the interests of good health.

Next followed instructions for taking the tablets one-half hour before meals. "They will *help* to reduce appetite and make it easier to *eat less*." Then the goal was restressed together with the absolute necessity for gradual, constant, weight loss.

Then came a page where the date and weight were recorded when treatment was commenced, together with height and age. Beneath this was a column where the patient was to record his weight each week. In order to replace self-deception by motivation this page was surmounted by "the sweetest sound in the English language"—the patient's own name. Sections were included for general and special instructions, as well as menus for a daily 1000 calorie diet. Last, but by no means least, was a section headed, "Reasons for Desiring to Lose Weight," to be filled in by the patient. Reasons suggested included "to be more attractive," "to increase life span," "to be popular," and so forth. We think our results show this last section to have been the most significant on the form.

Each patient was also given a numbered (unlabelled) bottle marked "A" or "B," containing tablets. Neither patient nor investigator knew what the tablets contained, thus constituting a double blind study.

The figures obtained during the trial showed that in patients who lost weight, *aspirin* plus *motivation* plus *diet* rendered results that were practically the equal of *anorexic agent* plus *motivation* plus *diet* (Table 2). Clearly, *motivation* must constitute the most important factor. Moreover, it now appears that aspirin may have greater value than hitherto realized and evidently proved more than a placebo in this study. A new role for aspirin as a cholesterolytic agent has recently been emphasized. Aspirin raises metabolic activity and has many other recognized therapeutic values, and may well be employed in the management of the obese patient. Certainly nervousness and insomnia occurred with far less frequency on aspirin than phenylpropanolamine.

Leanness

In view of the rather nebulous problems facing any scientific inquiry into variations of human form, we have appended an actuarial statement to Table 1. Fat kills; leanness is a consummation devoutly to be wished. For this very reason, leanness as a "disease" has been less studied than obesity.

We have tried to stress the metabolic dichotomy which apparently can channel the subject either towards gain or loss in certain states of endocrine disorder. The "change" can be one to fat or to lean. Hypopituitarism may be associated with Frohlich's syndrome here, Simmonds' cachexia there,

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TABLE 2

Double Blind Study of Aspirin and Phenylpropanolamine in Obesity

	RB-110A (Aspirin, 5 gr.)	RB-119A (Phenylpropanolamine, 25 mg.)
Number of pts.	66	74
Age range of pts.	10-63 years	9-55 years
Average age of pts.	32.3 years	34.3 years
Weight range of pts.	80-257¼ lbs.	80½-344½ lbs.
Average weight of pts.	165.6 lbs.	164.1 lbs.
Time range of diet	1-26 wks.	1-26 wks.
Average duration of diet	6 wks.	7.3 wks.
Dosage range	1-2 tablets 3 x daily, usually 1 tablet 3 x daily	1-2 tablets 3 x daily, usually 1 tablet 3 x daily
Number of patients who lost weight	45 (68.2% of total)	50 (67.6% of total)
Average weight loss per patient per week	0.81 lbs.	0.97 lbs.
Number of patients whose weight remained constant	10	10
Number of patients who gained weight	11	14
Average weight gain per patient per week	0.43 lbs.	0.77 lbs.
Percent patients noting appetite reduction	43.5%	61.5%
Percent patients noting nervousness	18.6%	24.4%
Percent patients noting sleeplessness	8.8%	33.3%

while hypothyroidism has both its fat and lean variants.

Therapy of Leanness

As in obesity, therapy may be considered from the standpoint of diet, exercise, glandular therapy, and anabolic agents.¹² As regards diet, the authors reiterate that in the absence of other disease or emotional or metabolic disorders, girth varies in direct proportion to caloric intake. The one varies in direct proportion to the other. Exercise raises metabolism and, therefore, stimulates appetite to produce weight increase. Moderation and grading are essential to healthy gain. Glandular treatment consists of specific replacement therapy as in diabetes mellitus, hypogonadism, or hypothyroidism. Thyroid hormone may also be used in anorexia nervosa where it may help produce a weight increase.

Leanness, per se, only becomes a serious problem when it is extreme in degree (e.g. anorexia nervosa). When secondary to severe disease (tuberculosis, thyrotoxicosis, etc.), the normal weight is regained following successful treatment of the cause. This is

usually encouraged by administration of vitamins, tonics, and various liberal diets. Formerly, the patient who wished to gain weight for cosmetic reasons first had serious disease excluded and then also received treatment with these time honored measures, perhaps supplemented by "hormones" in some cases. Today the iatrochemists have provided the clinician with some excellent preparations which are most effective in the treatment of the underweight child, the skinny girl, and men and women with malnutrition resulting from malabsorption or after gastrointestinal surgery.

The era of the newer anabolic agents was preceded by one in which the protein anabolic action of androgenic compounds such as testosterone or methyltestosterone was utilized. Though successful, these agents tended to produce masculinization and precocious puberty in children along with the more permanent disadvantage of premature epiphyseal fusion and final retardation of growth. In adult women, acne, hirsutism, lowering of voice, and enlargement of the clitoris were serious drawbacks to the preparations.

With the advent of the newer progestational agents such as Nilevar® and Norlutin®, the clinician's ideal of a compound possessing the protein anabolic action of testosterone without its "masculinizing effects" came one step nearer to realization. However, such preparations, unless properly employed, seriously interfere with the menstrual cycle, and are less than desirable for use in males. More recently, several anabolic agents which are less androgenic than methyl testosterone have become available. One of these, methandrostenolone (Dianabol®) has been given an extensive trial by our group and found more useful than methyl testosterone (Table 3) as an anabolic agent.

TABLE 3

Comparison of Methandrostenolone (Dianabol®) with Methyl Testosterone in Chronically Underweight Patients

Patient	Age	Methandrostenolone (M.A.)	Methyl Testosterone (M.T.)
M.M.	35	5.0 mg. daily x 8 weeks Gained 13½ lbs.; marked increase in appetite	10.0 mg. daily x 2 weeks Less appetite, felt weak, asked to be given more M.A.
J.H.	25	10.0 mg. daily x 10 days Great increase in appetite	10.0 mg. daily x 10 days No increase in appetite
D.H.	23	10.0 mg. daily x 4 weeks Gained ¾ lb.; increased appetite; slight acne	10.0 mg. daily x 4 weeks Lost ¾ lb.; lost appetite; same acne
M.E.M.	36	20.0 mg. daily x 7 weeks Gained 3 lbs.; slight acne	20.0 mg. daily x 4 weeks No weight gain; lost appetite; more acne

Clinical Trial with New Anabolic Agent (Dianabol®)

Therapy with methandrostenolone appears to offer a marked advance in treatment of conditions of underweight. The original animal work reported that the compound showed marked nitrogen retaining properties with virtually no androgenic side effects. In our series of women who were underweight, a dosage of two and one-half to 30 mg. per day was employed.

A pilot study in children revealed that only small doses should be used, for in some instances 2.5 mg. daily produced marked androgenic activity as evidenced by rapid onset of enlargement of the penis or clitoris and increased growth of pubic hair. These signs of acceleration of sexual development were accompanied by pronounced increase in rate of linear growth and by x-ray evidence of bone maturation. At present, we believe, the dosage for children should be 0.05 mg./kg. or less to avoid androgenic effects.

In our series of 70 adult women, all who received a dose of five mg. or more daily showed an average gain in weight of one-half to three-fourths of a pound per week. The maximum weight increases were seen with dosages of 10 mg. daily. Further increase in dosage beyond this figure did not lead to an increase in rate or amount of weight gain. With this dosage of 10 mg. daily, side effects (acne, mild voice changes) were few. When the dosage was raised to 20-30 mg. daily, some hirsutism was seen and occasionally hoarseness occurred.

The stimulation of appetite which methandrostenolone (Dianabol®) produced was quite striking. We compared its action in this respect with that of methyl testosterone on a milligram for milligram basis (Table 3). Here it was observed that patients already on Dianabol® noticed a decrease in appetite when they were switched to methyl testosterone. Moreover, the increase in weight which they had experienced on Dianabol® ceased on changing to methyl testosterone.

Two case histories are included to illustrate the effect of this anabolic agent—one a patient with Sheehan's syndrome, and the other a child with retarded growth who was markedly underweight.

CASE 1. Mrs. J.G.T. was first seen in September 1950 with a typical history that dated back to 1943 when she suffered severe shock and hemorrhage during parturition. Her chief complaints when first seen were weakness, amenorrhea, loss of weight, loss of sexual hair, poor appetite, loss of libido, nervousness, headaches, and an anemia that resisted iron and liver therapy. Her weight was 81 pounds; blood pressure 80/55; pulse rate 80. The vaginal smear was of the castrate type. From 1950 to 1959 the patient was maintained by pellet implantation of

hormonal agents such as testosterone, estrogens, and desoxycorticosterone acetate every six months along with small running doses of thyroid extract. On this regimen, her blood pressure increased to and was maintained at about 100-110/60-85; her weight ranged between 86-88 pounds. Menses were induced each month with cyclic progesterone therapy. On June 25, 1959 the patient weighed 88 pounds; blood pressure was 110/80, and the usual pellets were implanted. A dose of 10 mg. of methandrostenolone daily was added to her regimen. She returned on January 14, 1960, weighing 104 pounds, which was her accustomed weight prior to the onset of Sheehan's syndrome. The weight gain of 16 pounds was most dramatic. Some voice changes occurred on methandrostenolone and further medication with it was stopped. For the following six months, she was on her original sustaining hormone routine. When she returned for follow-up, her weight was 95 pounds, evidently stabilizing at seven pounds better than her weight level prior to Dianabol® therapy. Supplemental methandrostenolone at a dose level of five mg. per day has now been added to her usual regimen of therapy. Re-check one month later showed her weight to be 99½ pounds.

CASE 2. N.O., white female aged 11 years 10 months, was dwarfed and underweight. Her bone age was seven years six months. The sella turcica was normal. The vaginal smear was castrate in type. Stool examinations for parasites were negative. Her weight was 60¾ pounds; height 50¼ inches. PBI and cholesterol values were normal. She was placed on estriol 0.5 mg. t.i.d., methyl testosterone 2.5 mg. daily, and Proloid® grains one-half daily. One month later there was one-half an inch gain in height (50¾ inches) and one and three-fourths pounds (62½ lbs.) weight gain. Then five mg. daily of methandrostenolone was given in lieu of methyl testosterone. In one month her height increased to 53 inches and her weight to 67 pounds, but the clitoris showed some enlargement. Because of this the methandrostenolone dosage was reduced to one mg. per day. Three months later she was found to be 53¼ inches in height and 71¼ pounds in weight. At this time it was noted that some growth of pubic hair had occurred, which may have been puberal in nature. The Dianabol® medication was stopped. Her bone age had advanced to nine years three months. Eight months later—and without further androgen therapy—the child weighed 73⅜ pounds; her height had increased to 56⅜ inches, and the bone age had reached 11 years six months. In 13 months there had been a weight gain in this child of almost 13 pounds and an increase in height of 6⅛ inches. The enlarged clitoris has subsided.

Methandrostenolone proved preferable to methyl

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testosterone in this case and was indeed a real stimulus to weight gain and growth in this child.

Conclusions

(1) A double blind study in which a 1000 calorie diet along with either an anorexic agent (phenylpropanolamine) or aspirin yielded results which suggested that diet, motivation, and an anorexic agent were only slightly better than diet, motivation, and aspirin. The aspirin group had the advantage of less sleeplessness and nervousness. A certain group of patients failed to lose weight on either regimen, and a few gained weight. It was concluded that aspirin may be employed to advantage in the management of the obese patient.

(2) A new anabolic agent, methandrostenolone, was administered to underweight individuals. In the greater number a weight gain of 0.75 pounds per week was obtained when dosages of 10 mg. per day were employed. In children, a dose level of 0.05 mg./kg. or less per day should be used. In dosages higher than 10 mg. for adults and 0.05 mg./kg. for children, signs of virilization readily developed. The anabolic activity of methandrostenolone appeared superior to methyltestosterone.

(3) The recalcitrant few individuals who will not lose or gain weight on the various regimens outlined continue to defy the inexorable chain of revelations which biochemistry and genetics are presently yielding in the field of metabolism. To us, they are faithful representatives of one of biology's most powerful catalysts to variation and adaptability: the non-conformists. To them and their physicians, we can only offer the philosophy of that great observer in the field of human variation, emotion, and foible, Charles Dickens:

"A man must take the fat with the lean; that's what he must make up his mind to do in this life."

(David Copperfield, Chapter 51)

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GEORGIA PSYCHIATRIC ASSOCIATION

THE GEORGIA PSYCHIATRIC ASSOCIATION, district branch of the American Psychiatric Association, held its annual winter meeting on Sunday, February 19, at the Atlanta Athletic Club. Dr. Rives Chalmers, president, presided, and Dr. Leonard T. Maholick, Director of the Bradley Guidance Center, Inc., Columbus, addressed the assemblage on "Aspects of Current European Psychiatry with Special Emphasis on Its Application for American Psychiatry." This address was a summary of Dr. Maholick's impressions derived from a three-month visit

to Vienna where he observed the operation of the Hans Hoff Clinic at the University of Vienna, a state supported facility, and the private clinic of Dr. Viktor Frankl, exponent of existential psychiatry.

The following officers were elected for 1962-3: president-elect, Dr. Sidney Isenberg; secretary-elect, Dr. Louie Woodward; treasurer-elect, Dr. Julius Johnson.

The next meeting of the association will be held in conjunction with the annual MAG meeting and will take place on Sunday, May 7th.

THE DIAGNOSIS OF BRONCHOGENIC CARCINOMA BY CYTOLOGIC SMEARS

The prognosis is poor when a positive cytologic smear is obtained.

Earnest C. Atkins, M.D. and Harriet Leslie, A.B., CT (ASCP), *Atlanta*

THE PURPOSE OF THIS paper is to evaluate the accuracy of cytological examinations done at the Veterans Administration Hospital, Atlanta, Georgia over a period of one year. It compares the results of examinations done on sputum specimens and bronchial washings. It studies the value of repeated examinations, compares them with the relative frequency of positive findings at different locations in the lung and compares our results with these of others.

Material

Bronchial washings or sputum smears from 224 patients during 1957 have been reviewed. All cytologic material was collected and examined by the Papanicolaou method.⁷ One hundred forty-eight specimens were obtained from bronchial washings and 325 from sputum.

Malignant cells were reported in 39 patients of which one was a false positive. At surgery the lesion

was found to be inflammatory and re-examination of the smear showed it to be an error of interpretation. (Table 1)

Ninety-seven cytologic examinations were done on the 23 patients diagnosed as bronchogenic carcinoma. A total of 63 smears or 64.9 per cent contained malignant cells. Seventeen of the 26 studies made on material from bronchial washings were positive and 46 of the 71 smears made from sputum were positive. A comparison between positive cytologic reports of bronchial washings and sputum specimens from this group is presented in Table 2.

TABLE 2

A COMPARISON OF THE POSITIVE CYTOLOGIC SMEARS OBTAINED FROM BRONCHIAL WASHINGS AND SPUTUM SPECIMENS

Lobe	Positive Bronchial Washings	Positive Sputum Specimens
LUL	60.0%	75.0%
RUL	58.3%	50.0%
LLL	50.0%	72.7%
RLL	100.0%	70.5%
Average	68.0%	65.7%

TABLE 1

DIAGNOSIS OF PATIENTS WITH POSITIVE SMEARS

	No. of Patients
Bronchogenic Carcinoma	23
Carcinoma — Metastatic to Lungs	6
Diagnosis Clinically Positive, Bronchoscopy Biopsy Negative	5
Carcinoma of Larynx	3
Hodgkins Disease	1
No Malignancy	1
	39

From the Surgical Service and Cytology Section, Laboratory Services, U.S. Veterans Administration Hospital, Atlanta, Georgia, and Emory University School of Medicine, Atlanta 22, Georgia.

Written while Dr. Atkins was a resident in the Surgical Service, U.S. Veterans Administration Hospital, Atlanta, Georgia.

This paper has been approved for publication by the Hospital Research and Education Committee, VA Hospital, Atlanta, Georgia.

In a study of 1600 cases, McDonald³ found that sputum smears were 76 per cent accurate and bronchial washings specimens 39 per cent accurate. As noted in Table 2 bronchial washings from patients with carcinoma of the right lower lobe were positive in 100 per cent of the cases. Other observers noted a higher percentage of positive bronchial washings from the lower lobes while a higher percentage of positive sputum examinations were obtained from the upper lobes.

Papanicolaou studies were negative in 186 of the 224 patients studied. As shown in Table 3, 180 of these patients had no malignant disease. Of the other six, one had bronchogenic carcinoma, four

BRONCHOGENIC CARCINOMA / Atkins

had metastatic carcinoma to the lungs, and one had plasma cell myeloma. The possible cause for false negative results are: no communication of the bronchus; minimal communication of the bronchus; peripheral location of the carcinoma in the lungs; stenosis of the bronchus; carcinoma situated in the upper lobe; insufficient number of specimens, and misinterpretation of smears containing malignant cells.

TABLE 3
SUMMARY OF PATIENTS WITH NEGATIVE REPORTS

Non-Malignant Disease	180
Bronchogenic Carcinoma	1
Metastatic Carcinoma to Lungs	4
Plasma Cell Myeloma	1
	186

The accuracy of diagnosis depends upon the number of smears taken. Three cytological examinations per patient reduces the margin of error in making a valid diagnosis. The importance of multiple examinations is evident from the data presented in Table 4, which shows not only our experience, but that of others.

TABLE 4
PER CENT ACCURACY OF CYTOLOGIC EXAMINATIONS

Number Specimens	Taber	Philips	Umiker	Atkins and Leslie
1.0	70%	67%	76%	—
3.0	87%	90%	97%	—
4.1	—	—	—	99%
5.0	100%	100%	100%	—

Figures quoted from table in reference 2.

The observations of this series of 224 patients compare favorably with other studies.¹⁻⁵ Umiker and all¹ reported that 42 of 175 patients studied had carcinoma of the lung. The diagnosis of 29 cases or 69 per cent was made from cytology smears; 11 of the smears provided the only positive microscopic evidence of malignancy prior to thoracotomy on these patients. Prior to the introduction of cytology smears as a reliable diagnostic tool, the presence of bronchogenic carcinoma could be verified by bronchoscopy only in approximately 40 per cent of the cases. In the Umiker groups¹ series, a valid diagnosis was made in 69 per cent of the cases by combining bronchoscopic and cytologic examinations. In another series,⁵ this ratio was increased from 38 per cent by bronchoscopy biopsies alone to 76 per cent with the addition of cytologic smears.

It is of interest that these investigators¹ also con-

cluded that when the diagnosis is established from a positive smear, there is a three to one probability that the patient is inoperable.

Shabart⁴ stresses the value of combined diagnostic methods. In 64 proven cases of carcinoma, positive smears were obtained in 44 per cent of the patients, positive biopsies in 58 per cent; when both smear and biopsy was done, the presence of malignant cells was reported in 76 per cent of the cases.

Summary

The importance and accuracy of cytologic examination in the diagnosis of carcinoma of the lungs is stressed.

In a series of 224 patients, 23 cases of bronchogenic carcinoma were diagnosed by cytologic smears. One patient's bronchial washing was reported as negative before his death; at autopsy he was found to have carcinoma of the left lower lobe. Another patient who had repeated positive smears showed no evidence of carcinoma at thoracotomy.

Of the 23 patients with proven carcinoma (one or more positive cytologic examinations) 68 per cent of the bronchial washing specimens and 65.7 per cent of the sputum specimens were reported as positive. 64.9 per cent of the 97 examinations were positive for malignant cells. Eighty per cent of the cytologic smears from the right lower lobe involvement were reported as positive.

Our series compares favorably with those reported in the literature. The cytologic method of diagnosis of carcinoma of the lung has been of great value; however, the prognosis is poor when a positive cytologic smear is obtained. If malignant cells are present in the smear, there is a 3:1 probability that the lesion is inoperable. This was even less in our series with only five cases of 23 being operable.

Biopsies by exploratory thoracotomy are strongly recommended whenever carcinoma of the lung is suspected.

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THE GEORGIA PLAN FOR CASE DETECTION OF TUBERCULOSIS

Lester M. Petrie, M.D., *Atlanta*

With the advent of chemotherapy and modern surgical procedures early case detection is vital if successful rehabilitation is to be effected.

MY SUBJECT IS THE Georgia Plan for Case Detection of Tuberculosis which I will discuss under six headings:

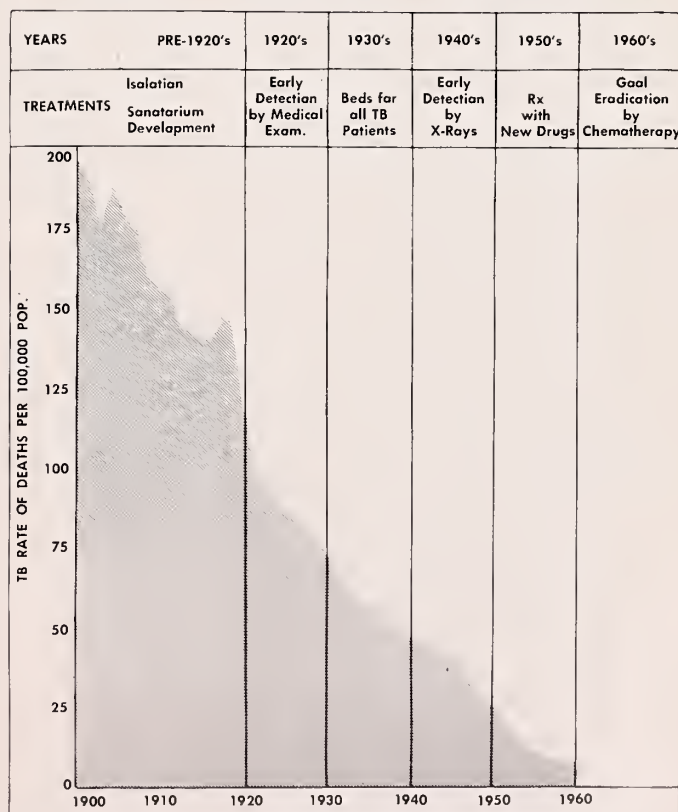
- I. As It Relates To Disease Control In General
- II. Specific Purpose—(Statewide eradication of tuberculosis transmission)
- III. The Epidemiological Problem
- IV. State Health Department Resources
- V. Other Resources
- VI. Pilot Project With Disease Investigators

As It Relates to Disease Control in General

A major function of public health is the eradication or the control of diseases. We dream of a time when there shall be no unnecessary suffering and no premature deaths. Rosenau said that we dream of these things, not with the hope that we individually may participate in them, but with the joy that we may aid in their coming to those who live after us. However, with some diseases, we, of our generation, have had the joy of participating in their control. Before he died, Dr. Abercrombie took pride in the fact that during his professional career—roughly the first half of the 20th century—he witnessed yellow fever, smallpox, typhoid fever, malaria, and diphtheria, as well as pellagra and certain occupational diseases brought under control. And now, the Arden House report has electrified us with the challenge that some of us here may also

have the privilege of participating in the eradication of tuberculosis, another disease of great interest to Dr. Abercrombie. He saw the tuberculosis death rates decline from 200 per 100,000 in 1900 to 7.1 the year of his death (1959). TB treatments have changed over the same years. Our goal for the 1960 decade is to wipe out TB by chemotherapy.

How TB Treatments Have Changed Over The Years



Read before the closing General Session of the Georgia Tuberculosis Association, October 1, 1960, DeSoto Hotel, Savannah, Georgia.

*Copied from August 1960
New Medical Material, Page 15*

GEORGIA PLAN / Petrie

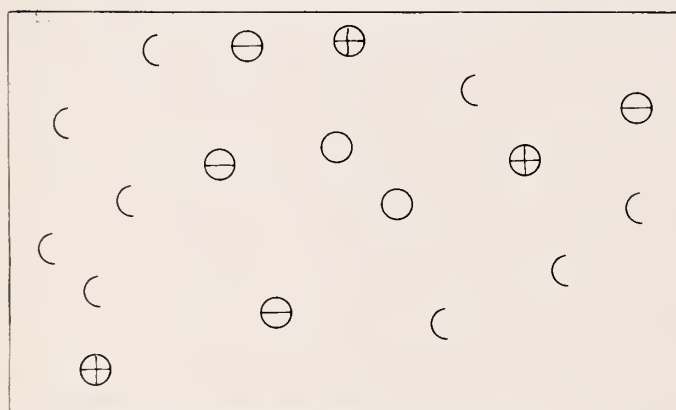
While the Arden House Report highlights treatment as the tool, it also emphasizes that no program can get off the ground unless the cases needing treatment are found first. I feel that none of the recommendations in the report are more important than case finding and constant program evaluation.

The Specific Purpose and Mission of the Statewide Tuberculosis Control Program

The specific purpose is the eradication of tuberculosis as a cause of illness and death. We will attempt to eradicate transmission. Needed for steady, sustained progress toward this goal are: early and adequate treatment of all cases; increased and more effective case finding; prevention of infection of the uninfected, and prevention of clinical tuberculosis among those already infected.

The Epidemiological Problem

Imagine a spot map of the State of Georgia with non-hospitalized cases, contacts, and suspects spotted by symbols as indicated below.



Non-hospitalized cases—July 1, 1960

⊕	Active, probably active, and activity known	3,630
⊖	Inactive	6,036
⌒	Contacts and suspects	?

The problem is not only to prevent dissemination of disease by the known cases, but also to identify and control unknown cases among the contacts and suspects.

State Health Department Resources

1. Battey Hospital—Rome
2. Tuberculosis Service—Atlanta
3. Evaluation Centers (seven serve 77 counties)
4. Local Health Departments.

Battey Hospital Functions Include: (1) treatment of hospital cases; (2) x-ray film development, interpretation, reports, consultations, and recommenda-

tions, and (3) recommendations for treatment at home.

Tuberculosis Service—Atlanta, functions include: (1) continue and expand evaluation centers; (2) furnish x-ray film, tuberculin, and drugs; (3) statistical and epidemiological analysis of records; (4) preventive medical, nursing, rehabilitation, and case work consultation services; (5) cooperate with medical schools in teaching and demonstrating increased awareness and acceptance by practicing physicians of their health responsibilities to the community as well as their responsibility to their private patients; similar cooperation with nursing schools, and (6) pilot disease investigator project under medical direction.

Evaluation Centers: local point of common referral for all agencies (hospital, Tuberculosis Service, health departments, private physicians, welfare, rehabilitation, etc.) for problem cases.

Dr. Bloodworth defined the functions of evaluation centers recently as including: (1) evaluate all suspects; (2) secure all contacts; (3) hospitalize all active cases, and (4) follow past hospital cases and aid rehabilitation of inactive.

Local Health Departments: all phases of tuberculosis control at the local level; its in their laps. Local health departments really have the job; all the other agencies and resources listed assist them.

What Are the Other Resources?

The Interagency Tuberculosis Committee has 17 agencies represented this year—federal, state, local, official, and voluntary. The potentialities of this Committee thrill me. This is their fourth year of operation and their program *this* year is built around the Tuberculosis Pilot Project being developed by the Health Department in Bibb, Jones, and Twiggs counties under the leadership of Dr. R. J. Walker, Jr., and the nursing supervision of Mrs. Myrtle Tomlin. The State Interagency Program Committee is recommending that a local Interagency Tuberculosis Committee be formed in these counties. The Interagency Program Committee is also recommending that the Georgia Tuberculosis Association encourage organized local tuberculosis associations to assist in giving leadership in forming other local interagency committees throughout Georgia.

The reason this development thrills me is because I believe the Health Department *has to have* organized community support of the welfare and rehabilitation and professional and other agencies. Without such help the job cannot be completed. With it I do not see how we can fail to progress.

Pilot Disease Investigator Project

Pilot Disease Investigator Project was developed after planning with U. S. P. H. S. Tuberculosis

Control Division, and is supported by them. Our chief disease investigator is a Public Health Service employee loaned to us by Dr. Blomquist to help us get started.

Pilot Demonstration: physician, Dr. Aselmeyer; Chief Investigator, Mr. Eller; two investigators (Spivey and Gleason), and a clerk.

Assigned duties of the investigators: the investigator acts as a technical representative of the Health Department in tuberculosis case finding, referral, and other techniques of control as directed by the health officer.

Specific assignments include:

1. *Case Investigation:* (A) help bring under adequate medical supervision those cases referred by the nursing service; (B) assist with arrangements for family support, and (C) assist with arrangements for rehabilitation.
2. *Suspect Investigation:* assure that suspects are brought to clinical evaluation.
3. *Contact Investigation:* interview assigned cases to identify their close contacts; refer these contacts for diagnostic services.
4. *Tuberculin reactor investigations:* bring tuberculin reactors to examination.

5. *Associates of tuberculin reactor investigation:* search out close associates of children who have positive tuberculin tests (recent converters) and refer them for diagnostic services in an effort to find source cases.

6. *Technical assistance:* maintain liaison with private physicians; carry on epidemiological surveillance, and promote tuberculosis control education.

7. *Records and reports:* prepare required records and reports; the keys to: follow-up, statistics, and evaluations.

Dr. Hanson paid deserved tribute recently to the Public Health Nurse. He mentioned the loading of more and more work on them without increasing their number. There is a limit to the amount of work that can be done unless additional hands are provided. Disease investigators will furnish extra hands and feet to help them, work with them—complement them.

We accept the challenge to meet the goals and standards in tuberculosis control described recently by Dr. Blomquist—at least in our pilot Disease Investigator Project—and we hope statewide as soon as possible.

47 Trinity Avenue

TREND IN HEALTH INSURANCE

THE TREND IN HEALTH insurance is toward coverages which employees can carry into their retirement years, the Health Insurance Institute said recently.

Seven out of every ten workers covered under group health insurance policies issued during 1960 have the right to retain their health insurance protection when they retire.

The Institute said its report was based on an analysis of data supplied by insurance companies responsible for 68 per cent of the total group health insurance premiums in the United States in 1959. The data sampling consisted of some 2,100 new group medical care coverages issued during 1960 protecting 276,886 employees.

The retention of the worker's health insurance coverage after retirement is achieved in two ways: by converting their group benefits to an individual policy upon retiring or by continuing the benefits on a group basis.

Some 129,000 employees, or 47 per cent of the total, have the right to convert to an individual policy upon retirement. More than 81,000 employees, or nearly 30 per cent of the total, have the right to continue their medical care benefits on a group basis when they retire. Some have a choice of either. Thus, 68 per cent of the

employees can retain their coverage when they retire, said the Institute.

The greater availability of coverages that continue into retirement is shown by contrasting the 1960 data with findings made at the end of 1959.

A study of group hospital expense plans then in force disclosed that the proportion of employees and dependents with the right either to continue or to convert their coverage upon retirement was 55 per cent.

In addition, a 1956 study by the New York State Department of Insurance showed some 45 per cent of people covered by group insurance had the right to continue or convert their coverage on retiring.

The 2,100 new group medical care coverages were issued on groups ranging from less than 25 employees to more than 500 employees. The average size of the less-than-25 groups was 11 persons, and the average size of the groups of more-than-500 persons was 1,700 employees.

The right for retired employees to convert to an individual policy was more common among the smallest groups, while the right to continue on a group basis was more common among the largest groups, said the Institute.

A Study of Thirty-Two Cases

MALIGNANT MELANOMA

Radiation in conjunction with surgery offers the best means of treating melanoma.

Frederick H. Bowen, M.D. and Robert A. Walton, B.A., *Jacksonville, Florida*

MALIGNANT MELANOMA, ALTHOUGH accounting for only 0.83 per cent of the deaths due to neoplasms in Florida for the last five years,¹⁸ has long been considered one of the most dangerous forms of cancer. Many types of therapy have been advocated, but there have arisen three schools of treatment. There is a group who advocate wide local excision with lymph node dissection in continuity: Pack,¹⁵ Johnson,⁹ Duperrat,⁷ Royster and Baker,¹⁶ Wilkins,²⁰ Meyer,¹² and Becker.¹ Clarke⁴ suggests a less drastic approach of local excision followed by watchful waiting, while Wilson²¹ says that dissection in continuity is "frankly a waste of time." Recently, another group is re-evaluating the use of irradiation in conjunction with surgery as an alternative to dissection in continuity: Dickson,⁶ Gertler and Gartman,⁸ Miescher,¹³ and Nitter.¹⁴ Pack¹⁵ and his co-workers have by far the largest series (1190 cases), and their results seem convincing; however, subsequent results by Wilson²¹ (136 cases), Dickson⁶ (254 cases), and others have conflicted with Pack's conclusions.

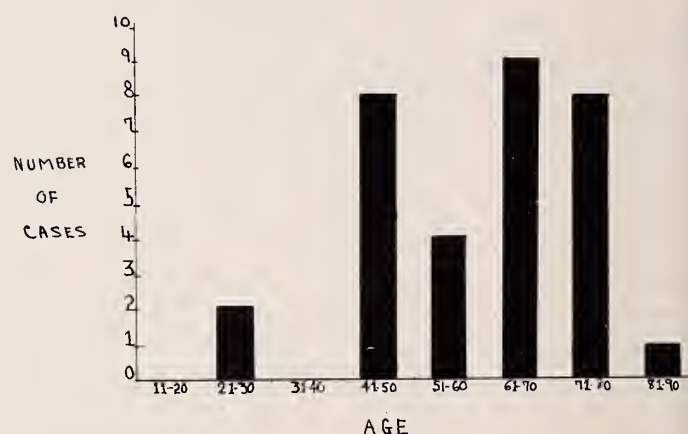
Incidence

In the Tumor Clinic of the Duval Medical Center, there are a total of 5072 cases recorded. Of this total 3849, or 75.9 per cent, were found to be malignant. The remainder were benign, not seen, or not diagnosed. The incidence of melanoma in all sites is 0.83 per cent of the malignant cases. The age range extended from 20 to 90, and the average age of onset was 60.0 years. The age distribution is shown in Table 1.

Read before the Southern Surgical Association and published in the Transactions of the Southern Surgical Association, Vol. 71, 1959.

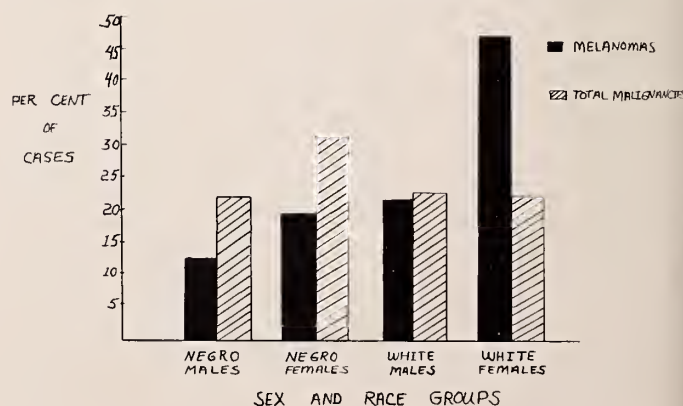
This investigation was financed by funds from the Florida State Board of Health and the Florida Division of the American Cancer Society.

TABLE 1. AGE DISTRIBUTION OF CASES OF MELANOMA



The incidence of melanoma as compared to the incidence of malignant disease in white and Negro males and females is shown in Table 2. The incidence of malignancies in Negroes is 52.8 per cent and in the white race 47.2 per cent. The percentage of melanomas, as compared to the total number of malignancies, is 68.6 per cent in the white race and 31.3 per cent in Negroes. It is of interest that 80

TABLE 2. — PERCENTAGE OF MELANOMAS AND TOTAL MALIGNANCIES IN SEX AND RACE GROUPS



per cent of the melanomas in Negroes occurred in the lower extremity.

The anatomic location of the primary sites is shown in Table 3.

TABLE 3
ANATOMIC LOCATION OF MELANOMAS

Location of the Lesion	Number	Per Cent
Lower Limb	15	46.8
(sole)	(3)	(9.3)
(leg and dorsum of foot)	(12)	(37.5)
Upper Limb	2	6.2
Head and Neck	4	12.5
Trunk	6	18.8
(breast)	(2)	(6.2)
Vulva	1	3.1
Anorectal	1	3.1
Eye	2	6.2
Generalized	1	3.1
Totals	32	100.0

Seventeen cases, or 53.1 per cent, reported a pre-existing mole, and four cases, or 12.5 per cent, gave a history of trauma to the site which subsequently developed a melanoma. The history in one of these patients disclosed a burn, sustained 50 years previously, which left a "brown mole" on the instep, and this developed into a melanoma. Other types of trauma were mechanically caused by tacks, glass, or "stone bruises," and chemical trauma to a "wart" by podophyllin was also reported. The average size of the lesion at the time of diagnosis was 2.4 cm. with extremes of 0.5 to nine cm. The average time from the first symptom to seeking medical treatment in the clinic was five months (24 cases). There was no correlation between the time of seeking treatment and the stage of the disease when first diagnosed.

Diagnosis by Stages

The stages were determined by the method of Sylven (quoted by Dickson⁶). Stage one was melanoma localized in the skin and included cases with satellite lesions, but clinically negative lymph nodes. Stage two comprised metastatic involvement of the lymph nodes, with or without a detectable primary melanoma draining the affected area. Stage three had evidence of remote metastases beyond the regional nodes. The number of cases diagnosed in each of these stages and the survival time of these cases in each stage is shown in Table 4.

Method of Diagnosis

The importance of microscopic examination of any lesion suspected of being a malignant melanoma is emphasized by the following data: 14, or 43.7 per cent, of the 32 cases were first diagnosed clinically and afterwards confirmed histologically. Histological diagnosis of malignant melanoma was made

TABLE 4
PROGNOSIS AS RELATED TO STAGE OF DIAGNOSIS

Stage of Disease	Number of Cases	Per Cent	Five Year Survivals		Survival Time in Months Average
			Number	Per Cent	
1	18	56.3	6	18.7	53.4
2	10	31.2	1	3.1	15.1
3	4	12.3	0	0	9.5

in 17 cases, or 53.1 per cent. There was one case of clinical diagnosis without histological confirmation. This lesion was removed by electrocautery and radiation, and accounted for 3.1 per cent of the total cases. This treatment was received elsewhere and resulted in arresting the disease for nine years after which a recurrence was treated by a radical node dissection.

Treatment

Initial treatment was divided into six groups: local excision, wide local excision, wide local excision with lymph node dissection, wide local excision with lymph node dissection in continuity, irradiation, and no treatment. The differentiation between local excision and wide local excision was arbitrarily placed at a point two cm. beyond the border of the melanoma, as described in the pathologic report. In some cases these measurements were made after formalin fixation and, of course, represent a wider margin of excision because of contraction of skin following chemical preservation. In two cases amputation of a digit was classified as local excision because there was less than a two cm. margin.

The type of initial treatment, the stage of the disease when first treated, and the mean survival time in months are shown in Table 5.

TABLE 5
SURVIVAL TIME IN MONTHS IN RELATION TO THE TYPE OF INITIAL TREATMENT

Initial Treatment	Total Number	Number Stage 1	Mean Survival Time (Months)	Number Stage 2	Mean Survival Time (Months)	Number Stage 3	Mean Survival Time (Months)
Local Excision	9	7	56.0	2	7.5	0	—
Wide Local Excision	8	6	31.0	1	1	1	5
Wide Local Excision With Lymph Node Dissection	4	1	84.0	3	5	0	—
Wide Local Excision With Lymph Node Dissection in Continuity	4	2	42.0	2	21	0	—
Irradiation	3	2	142.0	1	2	0	—
No Treatment	4	1	9.0	0	—	3	11.1

For statistical analysis, initial treatment is classi-

MALIGNANT MELANOMA / Bowen

fied as treatment carried out within one month of diagnosis. The initial treatment, unfortunately, in eight cases was not definitive. Table 6 shows the number of patients who had a recurrence of melanoma, the time after the initial treatment the recurrence was noted, and the number who received further treatment.

Of the patients receiving irradiation and having a recurrence, one had a wide local excision with lymph node dissection after the initial treatment. The second had a recurrence after nine years and, at that time, had a wide local excision with lymph node dissection. In the third case the treatment was palliative and resulted in some regression of the lesion, but the patient died after two months.

Discussion

The incidence of malignant melanoma is 0.83 per cent of the 26,922 Florida cancer deaths which occurred over a five year period.¹⁸ This is about half of the 1.5 per cent reported in Texas,³ but is similar to the 0.93 per cent incidence in Connecticut.³ The incidence of melanoma in proportion to cases of malignancy in the Duval Medical Center Tumor Clinic is exactly that of Florida, 0.83 per cent. The age distribution is similar to that reported by 11 other authors,⁶ but we had no cases younger than 20, in contrast to these reported results in which all authors reported cases younger than 20. These authors reported a total number of 2519 cases, showing 28 per cent involving the lower ex-

tremity, and 31.5 per cent involving the head and neck. On the other hand, our study shows a much higher proportion of melanoma of the lower extremity—46.8 per cent, and fewer cases of the head and neck—12.5 per cent.

There has recently been speculation about the frequency of melanoma in the Negro race.² Although the Negro population registered as having malignancy in the clinic comprise over half, or 52.8 per cent, there are twice as many melanomas in white patients with malignancy, and the white female is significantly more apt to develop melanoma than any other sex and race group.* Pack¹⁵ offers the explanation that women are more cancer conscious than men, and, therefore, more likely to seek medical treatment. White¹⁹ concludes that the prognosis is better in women than men, but our study does not support this conclusion.

It was not possible to study the fairness of skin and the tendency to freckle, and relate this to the development of melanoma as Lancaster¹⁰ and Pack¹⁵ have suggested, but it is felt that this is worth further study. The number of melanomas arising from pre-existing moles (53.1 per cent) compares well with Cunningham's report (quoted by Beerman, Lane, and Shaffer²) of 56.9 per cent of 1219 cases.

The average survival time (Table 4) is three and one-half times longer when diagnosis and treatment are begun in stage one than when these are delayed until stage two. The data shows that the length of time from the initial symptoms to the time of treatment has no relationship to the extent of metastasis. For example, there was one case in which 12 months elapsed from the first symptom to the time of treatment. At this time the melanoma was localized. In two other cases of only one month's duration, the melanoma had spread to the regional lymph nodes. These are in accordance with the conclusion that melanomas follow an unpredictable course.⁵

Melanoma cannot be diagnosed accurately on a clinical basis. Only 53.1 per cent of our cases were diagnosed clinically as compared to the results reported by Becker,¹ McMullan and Hubner,¹¹ and Swerdlow¹⁷ (See Table 7).

TABLE 6
RECURRENCE OR PERSISTENCE OF MELANOMA IN
RELATION TO THE INITIAL TREATMENT

Initial Treatment	Total Number	Number of Recurrences	Per Cent Recurrences	Mean Time of Recurrences	Recurrences Receiving Further Treatment	
					No.	Per Cent
Local Excision	9	7	77.7	31.5	4	50.0
Wide Local Excision	8	5	62.5	6.0	1	12.5
Wide Local Excision With Lymph Node Dissection	4	3	75.0	2.0	1	25.0
Wide Local Excision With Lymph Node Dissection in Continuity	4	3	75.0	10.0	0	0
Irradiation	3	3*	100.0	44.0	2	66.6
No Treatment	4	4	100.0	—	—	—

*One of these patients received palliative irradiation and died within two months.

TABLE 7
ACCURACY IN THE DIAGNOSIS OF MELANOMA

HISTOLOGICALLY DIAGNOSED MELANOMA		CLINICALLY SUGGESTED DIAGNOSIS
Becker	151	48%
McMullen and Hubner	87	50%
Swerdlow	27	59%
Bowen and Walton	31	45%

*A test for the standard error of the proportion comparing per cent of each race and sex group of malignancies and of melanomas resulted in the following *t* scores: white female 2.51; white male 0.135; Negro female 1.78; Negro male 1.515; where in each case *t* 0.05 is 2.04. (For *t* to be significant it should be greater than 2.04.)

The results of treatment are not easy to analyze because of many uncontrolled variables and the small number of cases, but the survival rate for five years of 21.8 per cent is within the ranges reported by Pack et al¹⁵ of 21.4 per cent, and by Dickson⁶ of 41 per cent.

A combination of radiation and surgery needs further study. The reports of Miescher,¹³ Nitter,¹⁴ and Dickson⁶ suggests that, with enough data, the teaching that radiation holds no place in the treatment of melanoma might be modified to: radiation in conjunction with surgery offers the best means of treating melanoma. The following case illustrates the occasional good result which follows the combination of irradiation and surgery in the treatment of melanoma.

Report of a Case

The patient, a 54-year old, white, married man, in 1941, noticed a small dark mole on his chest which began to itch and later increased in size. In January 1948, he began x-ray treatment for the lesion described then as one and one-fourth inches in diameter and protruding three-fourths inch above the surface of the skin. The lesion shrunk in size and healed over. In July and September he was given "rather intensive therapy through one port as there was some spreading over an area of about two inches." There was reported to be some extension to the axilla on January 4, 1949. At this time the patient was seen in the Tumor Clinic, and following a pathologic report of "malignant melanoma," a wide local excision with lymph node dissection in continuity was done. There was histological evidence that one node was involved with metastasis. The patient has been followed to date, and no evidence of disease has been detected after ten years.

Summary

The incidence of melanoma in all sites is 0.83 per cent of the malignant cases in Duval Medical Center, and is the same as the per cent of deaths from melanoma in the total malignancies in Florida for the last five years.

The average age of the onset of the disease is 60.0 years.

There is a significantly higher proportion of white females in this study who developed melanoma than any other race and sex group.

There was a high incidence (46.8 per cent) of melanoma on the lower extremity, and 80 per cent of the Negro cases were located in this region.

There was a low incidence (12.5 per cent) of melanoma of the head and neck.

Diagnosis of melanoma must be supported by histological study because a clinical error of 50 per cent is possible.

A combination of radiation and surgery needs further study and, in this study, offered the longest survival time. A case report was given of this type of treatment.

2000 Park Street

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MEDICAL TESTIMONY

Roy M. Lilly, *Thomasville*

OF THE 180 MILLION citizens of the United States, approximately nine million are injured each year in accidents involving automobiles, railroad trains, airplanes, ships, factory and workshop machinery, and in stores, fires, and by electricity.

As a result numbers of the medical profession find themselves called into court to testify more frequently than do any other class of experts.

Since the beginning of World War II, Workmen's Compensation claims attributable to injury and disease occurring in the course of employment, have increased to tremendous proportions. Many of these claims become disputes which require determination by the State Boards of Workmen's Compensation. All those in dispute require the testimony of medical witnesses.

The administration of personal injury claims becomes increasingly complicated by reason of traumatic neurosis, malingering, and many mental conditions following accidental injury.

Disputes impossible to resolve without medical testimony, arise as a result of aggravation of pre-existing disease of injury.

Doctors and lawyers have a common problem, along with insurance adjusters, judges and juries, and Workmen's Compensation Boards in resolving these personal injury controversies.

Despite the efforts of medical and bar associations toward better understanding between the members of the two professions, there continues to exist much misunderstanding between them. Most doctors detest being required to attend court. They misunderstand the necessity for cross-examination and feel that lawyers proceed by this device to question their professional ability and personal integrity. And law-

yers misconceive of the understanding most doctors have of trial procedures.

Each time a lawyer calls a medical witness for the first time, it is his duty to supply the witness with information sufficient to enable him to anticipate what is in store when he is confronted by the opposing lawyer.

For although civil procedure in American courts fall short of perfection, the adversary system under which our courts are operated is the most effective system yet devised to fulfill the purpose of all legal investigation, the ascertainment of the truth.

In every lawsuit involving personal injury there is a serious controversy between the parties. Each side is represented by a lawyer who is partisan, whose obligation it is to urge the court and jury to find in favor of his client. To that end he must present all of the favorable evidence within his reach both as to liability and damage or the absence of either or both.

The doctor on the other hand is not an advocate in the controversy. His duty is to report the facts as he knows them or as his opinion directs him. His effectiveness as an expert is destroyed if it becomes obvious that he has a preference as to the side which prevails. Often doctors come to be identified in legal circles as "plaintiff's doctor," "defendant's doctor," or "insurance company doctor," and these identities are acquired, quite innocently, because these doctors have given testimony in such fashion as to indicate partisan feelings for one side of a controversy or another.

Cross-Examination

Doctors should not resent being cross-examined by the opponent of the lawyer who calls him as a witness. Medical science is not an exact science and opinions differ among members of the medical profession just as they do in others. When a doctor

Excerpts of a paper presented at the mid-winter meeting of the Second District Medical Society, October 6, 1960, Radium Springs, Albany, Georgia.

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gives an opinion or states a conclusion, the opposing side has right to question the validity of such opinion or conclusion, to put it to the same testing that the opinions of other expert witnesses are subjected. The medical witness stands in the same position as other expert witnesses and the tool for evaluating the probative value of his testimony is cross-examination.

In each days activities we are all at one time or another cross-examiner or cross-examined.

There is no reason for a witness, lay or expert, to fear cross-examination unless he fears expressing the truth under oath and in public.

Preparation

A medical witness, who testifies for the first time should take the time to ask for and receive a preview of his part in the trial of the case. He should be told the rules of cross-examination; the meaning of and reason for the "hearsay" rule, the rule relating to admissions against interest and the effect of impeachment, and of other rules under which his testimony will be received.

For example, it is a common practice for cross-examiners to inquire into the compensation which the doctor has been paid or expects to be paid for attending the trial. The question is permissible and is material since it goes to his interest in the case. But there is no reason for him to be thrown off balance when the question is asked, probably in substantially the following form: "Doctor, I suppose you are being paid by the plaintiff to testify for him." The answer should be: "Oh, no, I am being paid only for my time, my testimony is not for sale."

Another "trick question" is: "Doctor, have you talked to anyone about this case?" If he says no, the jury knows that isn't true because any lawyer worth his salt will have talked to every witness he expects to use. If you say yes, the other lawyer may try to infer he was told how to testify. The only thing to do is to say frankly that he has discussed the case in advance of the trial and his only purpose is to report the facts.

Cross-examination strategy on occasion may lead an attorney to attack a medical expert's opinion by questioning him with respect to statements of a contrary view expressed in medical text books or scientific papers. Jurors for some reason seem to respect the authority of the written word in preference to oral testimony or opinion.

This inclination may be effectively overcome by the witness who may ask to see the writing, take his time to evaluate the conclusions in conflict with his own, explain the reason his opinion is more valid or distinguish between his and the contrary one.

Most important, however, the doctor must remain

composed when counsel begins this method of impeaching his conclusions.

Legal Necessity for Giving Oral Testimony

Where medical testimony is required in the trial of a personal injury case, it must be furnished by producing the medical expert in court for examination and cross-examination or by his deposition taken prior to trial. Doctors often ask if their written report furnished to the court would not suffice in lieu of their presence in court or instead of a deposition.

For the reason that opposing counsel are entitled to cross-examine every witness, to test the value or credibility of his evidence, the doctor's report or declaration not made in open court or by deposition will not be received by the court, unless stipulated between counsel.

Qualification As Expert

Since the medical witness is called to testify not only to what he has observed, but to state conclusions as well, it is necessary for counsel calling him to qualify him as an expert, as only expert witnesses are allowed under the rules of evidence to express opinions or conclusions. Thus it is that the first questions propounded relate to the witness' educational background, professional training, and experience. He is usually asked to state in detail his specialized training and experiences. This procedure is followed by the lawyer for the further purpose of impressing upon the jury the authority with which the doctor speaks, and the lawyer who calls the doctor will not forego having the doctor state his qualifications even though the opposing lawyer might state he is willing to stipulate qualifications.

Bring Records to Court

Since busy practitioners treat many patients between the time the accident under investigation and the time of trial, he may not remember all of the important facts relating to the plaintiff's injuries, his care and treatment. It is, therefore, essential to his value as a witness that he refresh his recollection of the case from records in his office prior to the trial. He should then go to court armed with his records to which he should refer in the presence of the jury—the latter serves to impress the jury that his observations and conclusions are worthy of credit.

While opposing counsel may look at the doctor's records thus used and cross-examine from them, if the records are not brought to court the opposing lawyer will usually seek to infer that the records contain information which the plaintiff and his doctor are deliberately withholding from the court and

MEDICAL TESTIMONY / Lilly

jury, that the records contain information unfavorable to the plaintiff's case.

History

Often in giving his testimony the doctor begins to relate as part of the history of the patient's case an account of the accident or cause of the injury. He rarely has personal knowledge of the accident and is relating that which has been reported to him by the patient. Opposing counsel will make immediate objection for obviously such history constitutes hearsay evidence which is not admissible.

Opinions As to Pain

As an element of damages in Georgia, and in most other jurisdictions, an injured plaintiff may be entitled to compensation for pain and suffering. For this reason, a testifying doctor will be asked at every opportunity whether the injuries sustained were a producing cause of pain. Often counsel will ask the doctor to describe types of pain, whether dull, aching, low grade, and persistent or sharp, piercing, and quickly over.

Obviously answers to such questions must rest upon conjecture on the part of the doctor. But such evidence is competent if properly elicited by plaintiff's counsel.

The plaintiff may be entitled to damages to compensate him for future pain and suffering and his future inability or decreased ability to earn a livelihood. The testifying expert will often be asked, therefore, to express his opinion of the probable future result of plaintiff's injuries. His testimony must be limited to what is probable in the ordinary course of nature. And while the doctor's opinion need not be based upon absolute certainty, he will not be allowed to state what "might" or "may" or "sometimes may" or "possibly might" develop. The result must be such as is probably or reasonably certain to develop.

Expert witnesses are allowed to give from the

witness stand their opinions based upon facts which have been proved by other witnesses. Such opinions will be sought by the propounding of hypothetical questions which assume facts which the evidence in the case will tend to establish.

Attendance At Court and Fees

Every person, expert and nonexpert, owes the duty of responding to lawful subpoena. Courts are vested with the power to compel attendance of witnesses and production of evidence. Medical testimony is generally given by two methods, by the personal appearance in court or by the doctor testifying by deposition in his office.

Lawyers are usually mindful of the great demands upon the doctors' time. Accordingly, it is the usual practice to arrange for depositions and where it is not practicable and the doctors' personal appearance is necessary at court, the lawyer calling him will arrange with the court to use the doctor out of turn or at such time as is most convenient for the doctor.

And while doctors cannot demand more than the fees of ordinary witnesses for attending court and testifying, they are permitted to charge extra compensation for their services in making preliminary preparation in advance of giving testimony. Lawyers realizing that as in their own profession, the doctors have as their only commodity for sale, their time, try to provide fair compensation wherever possible to do so.

A Need for Cooperation

In many cases, whether or not a plaintiff is entitled to recover compensation or damages depends upon information wholly within the knowledge of expert medical witnesses. In these cases justice cannot be done between the parties, plaintiff, and defendant, without the help of impartial factual reporters who are able to supply the court and jury with the information. While it is seldom convenient for a doctor to leave his office to testify in court, his testimony is essential.

218 E. Jackson Street

1960 BOOKLET OF REVIEWS NOW AVAILABLE

THE LATEST EDITION OF the annual publication "Reviews of Medical Motion Pictures" is now available upon request. It contains all of the reviews published in *The Journal A.M.A.* from January 1 through December 31, 1960. The purpose of these reviews is to provide a brief description and an evaluation of motion pictures which are available to the medical profession. Each film

is reviewed by competent authorities and every effort has been made to publish frank, unbiased comments. This booklet is prepared and distributed by the: American Medical Association, Communications Division, Department of Medical Motion Pictures and Television, 535 North Dearborn Street, Chicago 10, Illinois.

1961 CALENDAR OF MEETINGS

State

May 7-10—Annual Session, Medical Association of Georgia, Atlanta Biltmore Hotel, Atlanta.

May 10—Medico-legal Workshop, Crime Laboratory, Dept. of Public Safety, the Medical Examiners State of Georgia, and the Georgia Association of Pathologists.

June 7-9—Georgia Board of Medical Examiners, Examination and Endorsement, Atlanta and Augusta.

June 11-14—Georgia Pharmaceutical Association, Biltmore Hotel, Atlanta.

Sept. 8-9—Thirteenth Annual Meeting, Georgia Heart Association, Jekyll Island.

Oct. 12-14—Georgia Academy of General Practice, Annual Session, Jekyll Island.

Regional

Apr. 25-27—South Carolina Medical Association, Francis Marion Hotel, Charleston, South Carolina.

May 25-28—Florida Medical Association, Americana Hotel, Miami Beach, Florida.

Sept. 19-21—Kentucky State Medical Association, Brown Hotel, Louisville, Kentucky.

Sept. 25-26—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tennessee.

Nov. 6-9—Southern Medical Association, Municipal Auditorium, Dallas, Texas.

Dec. 5-7—Southern Surgical Association, Hot Springs, Virginia.

National

Apr. 20-28—American College of Obstetricians and Gynecologists, Americana Hotel, Bal Harbour, Florida.

Apr. 24-27—Aerospace Medical Association, Scientific Program, Palmer House, Chicago, Illinois.

Apr. 30-May 6—Conference on Internal Medicine, Bahamas Conferences, Nassau, Bahamas.

May 2-3—American Pediatric Society, Hotel Traymore, Atlantic City, New Jersey.

May 5-7—American Society of Internal Medicine, Eden Roc Hotel, Miami Beach, Florida.

May 8-12—American College of Physicians, Americana Hotel, Miami Beach, Florida.

May 8-12—American Psychiatric Association, Morrison Hotel, Chicago, Illinois.

May 15-19—Postgraduate Course in Gastroenterology, University of Pennsylvania Graduate School of Medicine, Philadelphia, Pennsylvania.

May 16-20—American College of Cardiology, Inc., Biltmore Hotel, New York, New York.

May 22-24—American Thoracic Society, Netherland-Hilton, Cincinnati, Ohio.

May 22-25—American Urological Association, Inc. Biltmore Hotel, Los Angeles, California.

May 22-25—National Tuberculosis Association, Netherland-Hilton, Cincinnati, Ohio.

May 25-27—American Gastroenterological Association, Drake Hotel, Chicago, Illinois.

May 29-31—American Gynecological Society, The Broadmoor, Colorado Springs, Colorado.

June 14-17—Society of Nuclear Medicine, Penn Sheraton Hotel, Pittsburgh, Pennsylvania.

June 19-23—Postgraduate Course in Current Aspects of Internal Medicine, State University of Iowa College of Medicine, Iowa City, Iowa.

June 22-26—American College of Chest Physicians, Hotel Commodore, New York, New York.

June 24-25—American Diabetes Association, Commodore Hotel, New York, New York.

June 26-30—American Medical Association, Annual Meeting, New York, New York.

Sept. 25-28—American Hospital Association, Atlantic City, New Jersey.

Sept. 30 - Oct. 3—College of American Pathologists, Seattle, Washington.

Sept. 30-Oct. 8—American Society of Clinical Pathologists, Olympic Hotel, Seattle, Washington.

Oct. 1-7—College of American Pathologists, Olympic Hotel, Seattle, Washington.

Oct. 2-5—American Academy of Pediatrics, Palmer House, Chicago, Illinois.

Oct. 2-6—American College of Surgeons, Conrad Hilton Hotel, Chicago, Illinois.

Oct. 8-13—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Illinois.

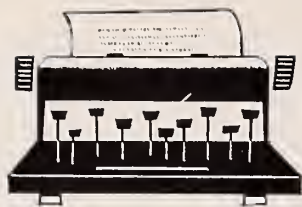
Oct. 15-20—Fourth International Congress of Allergology, the Hotel Commodore, New York, New York.

Oct. 20-24—34th Annual Meeting, American Heart Association, Miami Beach, Florida.

Oct. 22-27—American Society of Anesthesiologists, Inc., Statler Hilton, Los Angeles, California.

Oct. 25-29—American Society of Clinical Hypnosis, St. Louis, Missouri.

Nov. 27-30—American Medical Association, Clinical Meeting, Denver, Colorado.



editorials

Physician-Lawyer Code of Cooperation

ON MAY 3, 1956, a joint committee of dedicated members of the Medical Association of Georgia and the Georgia Bar Association met in Macon, Georgia. They had one object in view, to come up with a workable and abbreviated code of ethics that would be acceptable to both organizations. This was deemed necessary because we live in a world today full of insurance carriers, adjusters, compensation laws, and disability claims. This cooperative effort, though to some may seem slow, to the two professions it was astronomic, as far as our interprofessional codes are concerned, for today 50 per cent of our court cases are medical-legal cases. In a two day session, involving many hours of conversation, consideration, and debate, a workable code was finally conceived.

This code was then presented to the Georgia Bar Association where it was approved at its annual meeting in 1957 and in 1958 it was approved by our House of Delegates. A permanent committee was set up by both the Georgia Bar Association and the Medical Association of Georgia consisting of three members each, stating their duties and responsibilities with each association bearing their pro rata share of expenses. As a result, we now have in print the pamphlet, "Inter-Profession Code of Cooperation," governing professional conduct between lawyers and physicians. It is yours for the asking and it behooves each and every member of the Medical Association of Georgia to read this pamphlet and whenever possible to have at least one joint meeting a year of your county society with the bar association of your county.

There will arise no conflict between the members

of the legal and medical professions if both will stop to realize and admit their mutual responsibility to their profession and to the ethics established by them, to the public, to the individual clients and patients, and to their own honor, dignity, and integrity.

This code of cooperation is established to promote the public welfare by improving the working relationship of the two professions.

It is for the physician to determine the actuality or probability of fact pertaining to his patients condition.

It is for the attorney to determine how and under what circumstances such facts are to appropriately be presented.

It is recognized that facts are facts and can not be changed, but that the opinion of different physicians based on the same facts, may, and often do vary. Under no circumstance is a medical witness justified in suppressing medical evidence required by the courts in their search for justice.

It is part of the attorney's oath on his admission to the Bar of this State that he will not counsel or maintain any suit or proceeding which will appear to him unjust of any defense except as he believes to be honestly, debatable under the law of the land. It is not within the physician's prerogative to try to tell the lawyer how to try the case. Neither should a lawyer try to shade the physician's testimony. An attorney is justified in testing the competence and creditability of a physician's witness, but no ethical attorney will abuse, badger, or brow beat any witness and no court should allow it.

Both the lawyer and physician should recognize,

accept, and discharge their obligations to aid and cooperate with the courts and with each other, realizing that the proper and efficient dispatch of the business of the courts can not depend upon the

convenience of the litigants, the lawyers or the physician's witnesses, but that mutual cooperation of all concerned will pay dividends in the long run.

W. Bruce Schaefer, M.D.

Last Call for Annual Session

ON SUNDAY MAY 7 the 107th Annual Session of the Medical Association will convene in Atlanta. Five years have elapsed since the annual meeting has been held at the site of the Headquarters Office. It is anticipated that all members who have not had the opportunity to see and inspect our new Headquarters building will take this opportunity to do so.

Those who have not visited Atlanta recently will undoubtedly be pleased with the improved hotel and motel facilities which have become available within the city. Many may be surprised at the brisk building activity, particularly in the downtown area of Atlanta. Since the last annual meeting in Atlanta, at least three major buildings of greater than 20 stories have taken their place in the local skyline.

The Fulton County Medical Society, hosts for this

year's meeting, have expended great effort to assemble a really worthwhile program. A survey of the roster of out-of-state speakers, as well as Georgia participants, speaks well for the success of the program planners. The Woman's Auxiliary has planned a program of unusual interest to all the wives in attendance. In addition to the official program, many outstanding social events have been planned.

Since the recent improvement of highway and other transportation facilities within the state, it is anticipated that no great hardship will be encountered in getting to or from Atlanta. Since there are no major conflicts with meetings in the area at this time, it is hoped that each doctor and his family will make a special effort to attend this Annual Session. We shall look forward to seeing you there.

Electrical Anesthesia

RECENTLY THERE HAS been much discussion in the newspapers and semi-professional journals regarding the employment of electricity for anesthesia. This information was culminated in the *Journal of the American Medical Association* of February 18, 1961 with a report of two cases utilizing this technique. Since the statements in these articles left some gaps unanswered, I was fortunate enough to talk directly with the anesthesiologist involved, Dr. Leo

Fabian, and discuss with him exactly what takes place when this technique is used.

The signal generator is an inexpensive piece of equipment, having a frequency of 700 cycles, and most commonly utilizes a voltage of 20 to 30 with 50 to 80 milliamperes. With this device is an oscilloscope to gauge the cycling of this machine. Patients are premedicated in the usual fashion and are intubated either awake or under minimal amounts of

EDITORIALS / Continued

barbiturate with relaxation provided by succinylcholine. If the patient is anesthetized for intubation, he is allowed to awaken so that he can answer questions by motion of the head prior to the institution of electrical anesthesia. Two electrodes are attached, opposite each other, in the area of the temple.

After this preparation has been carried out, the current is turned on and immediately muscle spasms occur which require the administration of more succinylcholine. Electricity does not provide relaxation sufficient for laparotomy and the spasms represent a minor convulsion similar to that seen in electric shock therapy; they are not as severe since the amount of electricity is much less than that used in electric therapy. Intubation is required since ventilation has to be assured. In previous animal experiments, apnea was the rule and all of the animals had to have artificial ventilation. In human patients, respirations have varied in depth depending on the amount of succinylcholine administered and apnea has not occurred as a consistent factor. Nevertheless, control of ventilation is necessary.

Contrary to the impression given by the reports of this technique, Dr. Fabian informs me that all of the patients with one exception have had analgesia, but have not been unconscious during the procedure. They have been able to relate to the members of

the psychiatry department, interested in the effects of this procedure, everything that transpired during the period of surgery. Although they felt no pain, they had complete recollection of all events and no memory loss except for the transient period when barbiturate was used for induction.

Baseline EEG's, psychological and psychiatric determinations have been carried out on all of these individuals. The consensus based on this very small series is that there is very slight or no brain damage as result of this procedure. Certainly this would be indicated by the absence of memory loss and the patient's complete recollection of the entire surgical period.

For the moment, electricity is merely being substituted in the place of nitrous oxide, Fluothane,[®] cyclopropane, or other agents that are used to produce a minimum degree of analgesia and unconsciousness as a supplement to the relaxation provided by succinylcholine. The concept of a patient being absolutely awake during surgery is not new since this has been a factor in spinal anesthesia since it was developed. However, the production of this state by electricity does seem to be rather phenomenal, and it is possible that this investigation may open up an entirely new field in the relief of pain. At its present state of development it is by no means the ideal anesthetic and is not being offered by its investigators as a panacea for all existing problems in anesthesiology.

NEW MEDICARE MANUAL

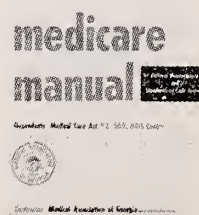
THE NEW MEDICARE MANUAL with the light blue cover dated March 1, 1961, is now available upon request by writing the Medicare Office in Atlanta.

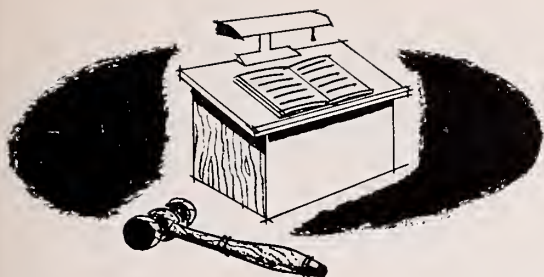
This Manual has been revised to include new Medicare provisions included in the 1961 Contract.

An added advantage to this new Manual is the maximum schedule of allowances which has been included with the procedure codes. It is urged, however, that physicians continue to charge their normal charges for a patient with an annual income of \$4,500 a year or

less so long as it does not exceed the maximum allowance.

All physicians are urged to participate in the Medicare program and to write or call for information from the Medicare Department, Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta 9, Georgia—TRinity 5-6303.





president's letter

THE EDUCATION OF A DOCTOR

THE EDUCATION OF A physician begins when he decides he wants to study medicine. It ends when he is eliminated from the practice of medicine. Although there are only four years as a "medical student," his years as a student of medicine only begin at his graduation from medical school.

The training of a physician now, like so many aspects of this world in which we live, is becoming more complex, with many ramifications, modifications, and specializations. We should look with a very critical eye and see if we need to re-evaluate the academic years, pre-medical as well as medical.

Originally the physician only treated diseases which were very apparent, and more often than not only predicted the course of a disease rather than changing it. The education of a physician today has to call upon the physicists, electronic engineers, mechanics, chemists, etc. Originally, medicine was more of an individualist's art; today, it must more often be practiced as a team effort which includes much ancillary personnel. We must not only guide in the education of the physician, but we must collaborate in the training of this related personnel.

Formal medical education is presented in the medical colleges, and it is fitting that this is where the majority of research projects are carried out. We well recognize that medical colleges have to give basic and fundamental concepts of pathology, physiology, biochemistry, etc., and that there always must be a fundamental difference between academic knowledge and the art and practice of medicine. However, there are many areas and instances where greater understanding and cooperation could be effected between the medical school faculties and the day-to-day practicing physician.

With the above facts in mind, the Council of the



MILFORD B. HATCHER, M.D.

Medical Association of Georgia recently passed the following resolution:

"Whereas, higher levels of education are needed to maintain and accelerate Georgia's recent industrial, agricultural and medical care gains, and

"Whereas, quality education for the growing college age population will require greatly increased faculties, throwing an enormous financial burden on the colleges and universities, and

"Whereas, professional education in the fields of medicine, dentistry, nursing and allied fields is an integral part of higher education and of especial concern to the medical profession in its objective of better health for the people of the State of Georgia.

"Now, therefore, be it resolved that the Council of the Medical Association of Georgia recognizes the need of increased financial aid for higher education and through official publications and pronouncements of its officers and staff and individual members will proclaim its interest and support."

Although "book knowledge" and scientific information are basic and fundamental for a physician,

PRESIDENT'S LETTER / Continued

these are not all. The art of practice along with proper knowledge enhances the stature of the individual in the practice of medicine. This can only be obtained from proper training, observation of human behaviour, respect for one's fellow man and those who have practiced before us, and good old common "horse-sense."

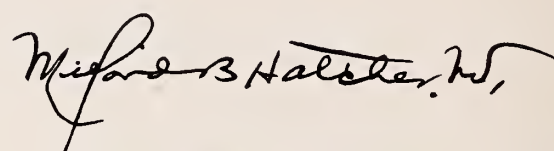
It is granted that a physician owes to his practice the highest of medical knowledge, but he also has a moral obligation to society, his profession, his family, and his patients to be ethical, honest, and of the highest integrity. From these characteristics in his daily life is the "image" of the physician reflected to the public.

Although in treating our patients from a medical standpoint, we are all too frequently faced with undesirable choices of procedure and must frequently make compromises; *no such compromise* can be justified in our ethical and professional decisions

as regards the necessity of treatment or the honest completion of insurance and compensation claims.

There is no doubt that our medical colleges are giving the students the best in scientific knowledge and research, but there is a question as to whether they are giving the proper emphasis to ethics, the art and practice of medicine, and respect for the patient as an individual.

Our medical schools expect our wholehearted co-operation, and we should certainly back them. However, the practicing physician and society should likewise obtain the wholehearted support of the medical faculties in giving the best possible care to the people of the State of Georgia.



President, Medical Association of Georgia

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mental health page

PSYCHOSEXUAL DEVELOPMENT

Julius T. Johnson, M.D., *Augusta*

THE TERM PSYCHOSEXUAL development is used for describing the interactions of body physiology, social attitudes, and the psyche. The early basis of our beliefs concerning psychosexual development was an outgrowth of Freud's theories concerning "Infantile Sexuality." This is one of the more controversial of Freud's theories. It is often criticized as being too narrow and is acceptable in many analytical circles only after being broadened to include many social and cultural modalities which the limitations of this article permit very little discussion of.

Since the pleasure derived from the satisfaction of psychological and physiological impulses is a matter of much importance in personality functioning, and the means of securing this satisfaction a good indicator of the degree of the personality development, Freud attributed a predominant place to this phase of personality to which he applied the term "sexuality." Selecting this term for pleasure-seeking impulses was unfortunate, since it erroneously carried the implications associated with the word through its usual application to adult sexuality and pleasure. In using the term "infantile sexuality" Freud never attributed to children the complex pattern of adult sexuality. If the restrictive use of the term sexuality is borne in mind, one may follow Freud's terminology tracing what should be a step by step development of the psychosexual aspect of personality development from its earliest to a mature,

heterosexual, socially-approved mating upon which the family is founded.

Psychosexual development is divided into various stages: (1) the pregenital stages which include the oral, anal, and phallic stages; (2) the latency stage, and (3) the genital stage. There is probably a good bit of overlapping of these stages, i.e. many pregenital impulses are present during the genital period and are satisfied by activity involved in the act of lovemaking such as kissing, caressing, etc.

Oral Stage: At birth a biological need for food arises and the infant receives satisfaction through sucking. Sucking not only relieves hunger but other and more complex tensions which arise. The mouth first becomes the part of the body in which interest, sensations, and activities are centered and through which gratification is secured. At about eight to 18 months of age the pleasure of biting is added to that of sucking and is referred to by some analysts as the period during which aggression appears.

Anal Stage: About the end of the first year with the gradual termination of the nursing period, the child begins to express interest in the excretory functions of the body. The interest in excretion is probably but an illustration of the fact that the exercise of primary body functions is a source of pleasure. The child becomes as interested in his excretory functions as a parent does in controlling them.

Phallic Stage: At about three years of age pleasur-

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

able interest shifts from the anal to the genital region. This continues until about the seventh year of life. There is concern with the difference between the sexes and the size, presence or absence, of the phallic organ. There is a predominance of genital sensations and stimulation of the sexual organs becomes a source of pleasure.

Latency Period: From six to the onset of puberty at 11 or 12 years of age, there is a relative decrease in sexual interest.

Genital Stage: At the onset of adolescence with the rapid physiological development of the sex organs and maturation of sexual and reproductive

capacities, stimulation of the genital and heterosexual interests and activities occur. The sexual area is only one aspect of the personality in which there is an inherent drive toward maturation.

An example of broadening the above theory follows: during the oral stage, the oral zone is a focus of a first and general mode of approach, namely, "incorporation" of what is brought to him. At first he is capable of getting only what is given to him, then he learns to get someone to do for him what he wishes to be done, thus developing the ground work for learning to get to be the giver. The ground work for learning to take and hold on to things is also being set. The oral stage thus sets the framework for the basic sense of trust and basic sense of evil which remain throughout life.

STATE SURVEY OF AIR POLLUTION BEGINS WITH ATLANTA

ATLANTA'S SHARE OF LOS ANGELES-TYPE smog has been termed at a "mild" level by a team of air pollution researchers after analyzing a week's sampling of the air over Atlanta.

The smog, which is shared by most large cities, results from the reaction caused by sunlight on automotive gasoline fumes together with nitrogen dioxide, a product of combustion. Smog is measured in terms of oxidants, a gaseous product of this reaction.

Oxidants in Atlanta reached 0.14 parts to a million parts of air on February 16, or about half of 0.25 ppm level that has caused eye irritation in Los Angeles. Oxidant levels on a typically smoggy day in Los Angeles can reach 1.0 ppm.

Nitrogen dioxide levels from all types of combustion reached 0.15 ppm in Atlanta, which is enough to cause mild smog.

Other gases in low levels in Atlanta's air were nitric oxide, carbon monoxide, and sulfur dioxide.

The sampling of Atlanta's air was carried out by engineers from the Fulton and DeKalb County Health Departments, the Georgia Department of Public Health, and the U.S. Public Health Service, with the cooperation of the air pollution engineer of the City of Atlanta and the U.S. Weather Bureau.

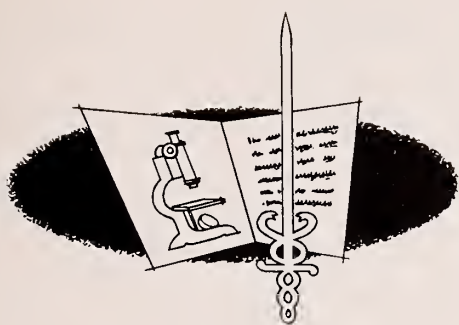
A number of air pollutants, both in gas and particle form, were measured by special instruments on the roofs of the Fulton County Health Department building and the Georgia Department of Public Health building. Visibility was also measured.

R. P. Lewis, industrial hygiene engineer, Georgia Department of Public Health, and Frank Bell, consultant sanitary engineer, U.S. Public Health Service,

Washington, D. C., were in charge of the sampling. The Atlanta air sampling is part of a statewide survey of air pollution which began in January and will continue until June 30, to determine whether Georgia needs a full-time program for air pollution control such as is carried out by health departments in several states. The statewide survey is being carried out by means of questionnaires to district public health officers, industry officials, city officials, and county agriculture agents. The U.S. Public Health Service has assigned Sam McKee, an industrial engineer, to full time service with the Georgia Department of Public Health during the survey.

Particles in the air, as distinguished from gases, include dust, soot, and pollens (not now in season). Measurements in Atlanta on the first day of the sampling, just before the recent rains, showed 186 micrograms per cubic meter of air over the State Health Department building and 152 over the Fulton County Health Department building. This compares with previous samples over Atlanta of as low as 46 and as high as 338 in recent months. Atlanta's usual average is 100 to 150. This compares favorably with London, England, which measures four or five times as much as most U.S. cities, Mr. Bell said. One reason for London's high level is the large number of individual room heaters burning coal, which gives off a large amount of smoke over the city.

Mr. Lewis and Mr. Bell pointed out that the sampling period in Atlanta was generally windy and rainy, which caused low levels of pollutants measured. Additional sampling over a longer period is needed, they said, to determine seasonal variations and trends.



cancer page

THE DENTIST AND CANCER

Minor Turrentine, D.D.S., *Columbus*

P RIMARY CANCER OF THE oral cavity comprises about seven per cent of all malignant lesions in men and about two per cent of all cancer in women. When the incidence of cancer of the skin of the face and lip is added to this figure, it becomes apparent that the dental practitioner is in a position to observe about 15 per cent of all human cancer. The strategic role of the dentist in the fight against cancer has been widely recognized by the medical and dental professions and by governmental and other agencies interested in the cancer problem.

A fairly large segment of our population receives more or less regular dental care. This provides a unique opportunity for periodic examination of the oral cavity and adjacent structures with the increased likelihood of detecting cancer in its earliest and most curable stages.

The dental profession is aware of its important contribution to cancer control. During the last decade, the nation's dental schools have sharply increased their emphasis of teaching in the areas of oral diagnosis, oral pathology, and related fields. Most schools now present separate courses in oncology and the dental student frequently attends the hospital tumor board and out-patient clinics. The recent dental graduate has had considerable instruction in the indications for and technics of biopsy, the

use of exfoliative cytology studies and is aware of most aspects of the oral cancer problem. Increasing numbers of dentists are becoming qualified in the dental specialties. In most instances their training programs include considerable emphasis in the field of neoplastic disease. The increasing popularity of dental internships provides dental graduates with additional experience with the cancer patient in a hospital environment. The American Cancer Society currently is supporting Clinical Fellowships in a number of dental schools. Most of these Fellows are preparing for careers in dental education. Dental scientists have also made significant contributions to the understanding of basic problems of oral neoplasia.

Dentistry's interest in the cancer problem is also manifested by an increasing number of programs related to cancer being presented at local, state, and national meetings. In many regions, special post-graduate meetings devoted to oral cancer have been sponsored by the American Cancer Society, dental societies, or dental schools. These have been enthusiastically and well attended by practicing dentists.

The chief contribution of the dentist to the control of oral cancer relates to his recognition of the early, usually asymptomatic, lesion which is discovered during the course of a careful clinical

Approved by Professional Education Committee, Georgia Division, ACS.

examination of the oral mucous membranes. Carcinoma-in-situ and early invasive carcinoma of the oral mucosa may present very minimal findings and a high index of suspicion must be maintained at all times. Recent reports have demonstrated the value of exfoliative cytology in the diagnosis of these early, often clinically innocuous-appearing, lesions. Increasing numbers of dentists are also utilizing the services of the pathologist for the routine examination of tissues excised from the mouth. Although the vast majority of such lesions are benign, this practice is resulting in the increased detection of early, unsuspected malignancies.

When the dentist encounters a lesion which is clinically highly suspicious of cancer, his responsibility will generally be best discharged by prompt referral of the patient to a qualified cancer therapist.

In other instances he may elect to perform the biopsy himself. In either case, he must make certain that the patient obtains qualified care in the shortest possible time.

Dentists seldom wish to assume major responsibility for the treatment of oral cancer. In many of our larger centers, however, well-trained dentists are a valuable part of the "team approach" to the treatment of oral cancer. The services of the dentist are of great value in the preparation of the mouth for surgery or radiation and in the design and construction of various types of splints. Dentists also make an important contribution to the welfare of the postoperative cancer patient in the construction of maxillofacial prostheses. The dental profession is charged with the responsibility for maintaining oral health. Dentists are anxious to assume their full share of responsibility for the diagnosis of oral cancer.

SALK VACCINE SHOTS URGED

THE MEDICAL PROFESSION, the U.S. Public Health Service, and the National Foundation are working together in an all-out drive to get as many persons as possible to take Salk vaccine shots before the summer polio season starts.

The Sabin live polio vaccine will not be available in quantity this year.

The Salk vaccine campaign drive is directed particularly at children and younger adults in the lower economic groups.

Dr. Julian P. Price, Florence, S. C., chairman of the American Medical Association's Board of Trustees, pointed out that many children and younger adults in the lower income groups have not been inoculated against polio.

"As long as 'islands of unvaccinated persons' exist even within well-vaccinated communities, polio epidemics remain a serious threat," Dr. Price said.

Dr. Luther L. Terry, Surgeon General of the Public Health Service, emphasized the need for immunizing infants. He also said that the PHS will encourage behavioral studies to determine reasons why some people refuse to take polio shots. It is hoped that then methods may be devised to overcome such refusal.

Dr. Terry called particular attention to the findings of the PHS's Advisory Committee on Poliomyelitis Control that the recommended dosage schedules may be modified to permit the administration of three shots of

Salk vaccine before summer to persons who have not had any vaccine before.

Dr. Price stressed that success of the "babies and breadwinners" polio vaccine campaign depends on joint activity at the local level by medical societies, boards of health, and voluntary health agencies. He expressed confidence that the more than 2,000 state and county medical societies throughout the country would cooperate wholeheartedly.

"Contrary to recent reports (in Scripps-Howard Newspapers)," Dr. Price said, "the A.M.A. is strongly behind every effort to encourage the public to take advantage of the Salk vaccine without delay."

The Advisory Committee urged that "immediate steps . . . be taken by all interested groups to intensify drives for vaccination with the formalin-inactivated (Salk) vaccine." The Committee also endorsed the plan to direct the campaign particularly at the lower socioeconomic and younger age groups.

The Committee recommended that the first available supplies of the Sabin live, oral vaccine be utilized in the following priority order:

1. Epidemic control, investigations, and community studies.
2. Immunization of infants and pre-school children.
3. Selected area immunization of those segments of the population that are least well immunized.



heart page

PATHOLOGICAL CHANGES IN MYOCARDIAL INFARCTION

Hamil Murray, M.D., *Gainesville*

ISCHEMIC MYOCARDIAL NECROSIS, or myocardial infarction, is the most serious and important form of vascular heart disease. It occurs when there is an excessive discrepancy between the oxygen requirement of the myocardium and the oxygen supplied to the myocardium. This discrepancy may be the result of a wide variety of physiological or anatomical abnormalities involving the entire cardiovascular system or a specific component of the system such as a coronary artery. Physiological abnormalities include such states as shock, cardiac arrhythmias, decrease in the oxygen-carrying capacity of the blood, etc., and anatomical abnormalities include such processes as ostial narrowing of coronary arteries in luetic aortitis, polyarteritis nodosa involving the coronaries, and coronary arteriosclerosis.

Coronary arteriosclerosis is by far the commonest cause of inadequate blood supply to the myocardium, accounting for some 95 per cent of all cases. This process is usually a manifestation of generalized arteriosclerosis, although there is no absolute parallel in the severity of the disease in coronary and systemic arteries. Thus, one cannot necessarily derive accurate information concerning the state of the coronary arteries from examination of the peripheral arteries by one means or another.

In early coronary arteriosclerosis there is a haphazard distribution of atheromatous plaques in the intima of the vessels and these are most commonly found in the anterior descending branch of the left

coronary, followed in order of frequency by the circumflex branches of the left and right coronaries. One of these plaques, by enlargement, may slowly obstruct the lumen of the vessel; at other times, sudden occlusion results from thrombus formation at the site of the plaque, hemorrhage into the plaque, ulceration of the surface, etc. As the disease progresses, the plaques become larger and more numerous, the lumen narrows, and calcification of the plaque and also the media of the vessel (Monckeberg's sclerosis) may occur.

Normally, the coronary arteries function as end arteries, that is, there are few anastomoses between the two major vessels or between their smaller branches. For this reason, the area of myocardium supplied by a given artery is anatomically quite specific. When slow occlusion of an artery occurs over a long period of time, however, anastomotic channels between its branches and those of another major coronary artery may develop and thus one vessel may supply blood to an area of myocardium normally supplied by another artery.

The slow development of coronary arteriosclerosis with chronic ischemia of the myocardium results in atrophy and subsequent replacement of muscle cells by fibrosis, and to scarring and sometimes eventual calcification of heart valves. Significant coronary arteriosclerosis accompanied by diffuse interstitial fibrosis of the myocardium constitute the minimum anatomic criteria of arteriosclerotic heart disease.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Cardiac enlargement may or may not be present.

Myocardial infarction may be superimposed upon arteriosclerotic heart disease, or may occur in a previously undamaged myocardium through any mechanism bringing about an excessive discrepancy between the supply and demand of oxygen by the muscle. This may be caused by one of the mechanisms mentioned above, or may result from an increased metabolic need of the myocardium without a compensatory increase in blood flow through the coronaries.

The size and location of the myocardial infarct depend upon a variety of factors, among them the site of the occlusion and the presence and efficiency of collateral circulation. Most myocardial infarcts involve the left ventricle, those of the right ventricle and atria occurring uncommonly. This is to be expected in view of the frequent involvement of the left coronary artery, particularly its descending branch, by arteriosclerosis, and also because occlusion of the right coronary distal to the first five or six cm. produces its effects on the posterior portion of the left ventricle and the interventricular septum. The gross appearance of the area of infarction depends upon its age. If death occurs within a few hours after the onset, there may be no gross or microscopic changes in the heart muscle, and after autopsy one must arrive at a diagnosis of myocardial infarction from the clinical history, EKG findings, the presence of coronary occlusion, etc. In some 12 hours the area of infarction becomes paler than the adjacent muscle and may be softer in consistency. Microscopically, there is coagulation of muscle fibers, the fibers stain more intensely, and the cross striations of individual fibers are indistinct. Near the end of 24 hours the involved area becomes more well defined grossly due to hyperemia of its edges and the development of a pale, grayish tan

color. Seen under the microscope are frank necrosis of muscle fibers, nuclear degeneration, interstitial edema of connective tissue, and beginning accumulation of polymorphonuclear leukocytes. In four to ten days shrinkage and fragmentation of muscle cells occur and fat stains will demonstrate sudanophilic material responsible for the yellowish tan color of the area of infarction that can be seen grossly at this time. Large numbers of polymorphonuclear leukocytes are present and increased numbers of macrophages appear. During this time the area of infarction is at its weakest and rupture of the heart with hemopericardium and tamponade may occur; rarely the interventricular septum ruptures. If the area of necrosis involves the epicardium, a localized fibrinous pericarditis develops which may be the source of a friction rub heard on auscultation. A similar localized endocarditis may result in the formation of a mural thrombus, and fragments of this, breaking loose, may produce embolic phenomena.

After two weeks peripheral granulation tissue forms, connective tissue proliferation increases, and the cellular infiltrate consists chiefly of macrophages. Quantities of hemosiderin can be seen and much of the degenerated protoplasm of muscle cells has been resorbed. Progressive fibrosis takes place during the next four to six weeks and the areas of scarring, at first well vascularized, become less vascular through shrinkage and hyalinization of scar tissue. Eventually this becomes dense and white and much later may become calcified. If the area of scarring is large enough and involves the entire thickness of the ventricular wall, this inelastic fibrous tissue may balloon outward with the formation of a cardiac aneurysm.

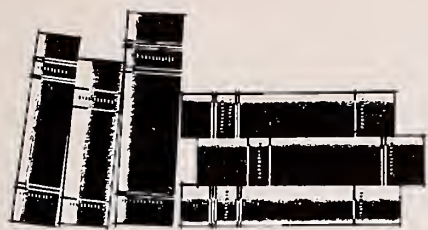
If, after healing of the area of infarction, sufficient intact myocardium remains and the conduction system is undamaged, the heart will function adequately. If not, heart failure and various abnormalities of rhythm may be sequelae.

FLORIDA DIABETES ASSOCIATION

EACH YEAR THE Florida Diabetes Association offers a prize for the best paper on diabetes by a medical student or resident. The winning paper will be presented by the author at the annual meeting of the Association at

the Balmoral Hotel, Miami Beach, in October.

Entries should be submitted to the President, M. B. Seltzer, M.D., 614 North Peninsula Drive, Daytona Beach, Florida, by July 1, 1961.



physician's bookshelf

BOOKS RECEIVED

Ritchie, Douglas, **STROKE**, Doubleday and Co., Inc., Garden City, N. Y., 1961, 192 pp., \$3.50.

Beckman, Harry, M.D., **PHARMACOLOGY**, W. B. Saunders Co., Philadelphia, Pa., 1961, 805 pp., \$15.50.

Montgomery, Thaddeus L., M.D. and Greenblatt, Robert B., M.D., **CLINICAL OBSTETRICS AND GYNECOLOGY**, Vol. 3, No. 4, Paul B. Hober, Inc., New York, N. Y., December 1960, 1,144 pp., \$18.00 per year, published quarterly.

Marble, Henry C., M.D., **THE HAND**, W. B. Saunders Co., Philadelphia, Pa., 1960, 207 pp., \$7.00.

MacQueen, Ian A. G., M.D., **A STUDY OF HOME ACCIDENTS IN ABERDEEN**, Williams & Wilkins Co., Baltimore, Md., 1960, 100 pp., \$3.50.

Rushmer, Robert F., M.D., **CARDIOVASCULAR DYNAMICS**, W. B. Saunders Co., Philadelphia, Pa., 1961, 503 pp., \$12.50.

Lawford, Giovanna, **THE HUMAN FRAME**, Doubleday & Co., Inc., Garden City, N. Y., 1961, 109 pp., \$95.

Ulett, George A., Ph.D., M.D., and Goodrich, D. Wells, M.D., **A SYNOPSIS OF CONTEMPORARY PSYCHIATRY**, The C. V. Mosby Co., St. Louis, Mo., 1960, 309 pp., \$6.50.

Peddie, George H., M.D. and Brush, Frances E., R.N., **CARDIOVASCULAR SURGERY**, G. P. Putnam's Sons, New York, N. Y., 1961, 170 pp., \$2.75.

Council on Drugs of the American Medical Association, **NEW AND NONOFFICIAL DRUGS—1961**, J. B. Lippincott Co., Philadelphia, Pa., 1961, 849 pp., \$4.00.

REVIEWS

Smith, Carl H., M.D., **BLOOD DISEASES OF INFANCY AND CHILDHOOD**, The C. V. Mosby Co., St. Louis, Mo., 1960, 572 pp., \$17.00.

THE COMPLEXITIES OF MODERN hematology provide a challenge for the biochemist, the physical chemist, the enzymologist, the geneticist, the physicist, and the immunologist. Coagulation, with its multiplicity of inter-

acting physical and chemical agents, is beyond the scope of most modern clinicians.

Pediatrics adds to this bewildering array of facts and phenomena the complicating features of growth and development, rendering the interpretation of data the most difficult, and providing a dimension that to date has been almost impossible to probe.

Dr. Carl Smith, who has long been recognized as one of the leaders in the field of pediatric hematology, has attempted, in his new text: "Blood Disease of Infancy and Childhood," to review the many aspects of this subject. The result is a laudable compilation of facts which will aid the clinician materially in making judgments in the field of hematology.

This text reviews the peculiarities of the well known disorders of the blood as they are seen in infancy and childhood, and points up the differences as they relate to diagnosis and therapy. The approach is straightforward and, at times, a bit dogmatic, but the subject is covered succinctly and well.

The book is clearly intended as a reference manual for those who are in the clinical practice of pediatrics.

Sanford J. Matthews, M.D.

Abramson, Harold, M.D., **RESUSCITATION OF THE NEWBORN INFANT**, The C. V. Mosby Co., St. Louis, Mo., 1960, 274 pp., \$10.00.

THIS MONOGRAPH BRINGS together under one cover much of the current knowledge of the physiology of the perinatal period pertaining to the unborn and newly born infant. In proper intellectual sequence this is presented and integrated in a very readable fashion so that the therapeutic indications, tools, and drugs available for use are presented for comment.

Throughout each chapter the approach of stating known facts, areas of ignorance, and differences of opinion is commonly used, then to be followed by the author's opinion as to proper conclusions or therapy. The great range of important considerations in such a short work results in some chapters in extreme shortness of discussion or in the statement of the author's opinion without discussion. This is partially compensated for since each chapter is followed by an extensive bibliography.

Underlying the text there is a strong plea for rational therapy based on current knowledge, rather than tradi-

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

PHYSICIAN'S BOOKSHELF / Continued

tion. This book contains information well worth seeking for medical student, resident, or practitioner dealing with perinatal problems.

Robert C. Garner, M.D.

Meyer-Schwickerath, Gerd, M.D., LIGHT COAGULATION, The C. V. Mosby Co., St. Louis, Mo., 1961.

IN THIS SMALL VOLUME are published the fundamental facts and development problems of light coagulation to the retina, its use in external eye lesions, intraocular tumors, and vascular proliferations. Light coagulation to the eye as practiced by the author is being used by increasing numbers of clinics and hospitals though the initial cost of the basic instruments is rather high.

The author explains the limitations and extensive possibilities in the use of light coagulation, with its most frequent use being to seal the retina to the choroid in nearly normal eyes with macular holes. Many case reports and illustrations of use in eye problems of disease, particularly angioma and other vascular disorders, are included. Technical problems are discussed.

This book introduces the reader to light coagulation for the eye and is the beginning for extensive new progress and research in ophthalmic retinal therapies, with full recommendation to ophthalmologists who would keep abreast.

W. Granville Tabb, Jr., M.D.

Garland, Joseph, M.D., THE PHYSICIAN AND HIS PRACTICE, Little, Brown and Co., Boston, Mass., 1960, 270 pp.

THE PURPOSE OF THIS book is to provide a source of practical information for the young physician who is entering private practice or for the physician who is already established. It is composed of a series of unconnected essays by 18 authorities writing on medical and medically related topics.

An attempt is made to give information on matters not ordinarily emphasized in medical school curricula or in postgraduate training programs. The relationship of the physician to his family, to the community, and to other doctors is examined. Practical advice is offered on the establishment of an office, on the advantages and disadvantages of individual practice compared to group practice, and on the physician's medicolegal responsibilities. One chapter devoted to the choice of further specialized medical training seems inappropriate in a book designed for those already prepared to enter private practice or already established.

The book is well written and may be read with ease.

It provides useful information for the physician already established in private practice and those preparing for it.

Charles B. Upshaw, Jr., M.D.

Meares, Ainslie, M.D., THE SYSTEM OF MEDICAL HYPNOSIS, W. B. Saunders Co., Philadelphia, Pa., 1960, 484 pp., \$10.00.

INCREASED LAY AND MEDICAL interest in hypnosis has created a knowledge and interpretation with approved scientific medical modality in dealing more adequately with patients in various conditions and states of stress and strain.

The book is easily readable, interesting, delightful, with clarity of subject and case reports. The general practitioner's library is incomplete without this outstanding contribution.

The indication of hypnosis by motivation and dealing with the emotional and disturbed persons, habits, obstetrics, gynecology, surgery, and anesthetics are amply covered.

Prestige is with limitation of ones techniques according to his training by doctors of medicine, dentistry, and psychology.

Clifton G. Kemper, M.D.

Wolstenholme, G. E. W., O.B.E. and O'Connor, Maeve, B.A., HAEMOPOIESIS, Little, Brown, and Co., Boston, Mass., 1961.

THIS BOOK REPRESENTS the edited proceedings of the 60th Ciba Foundation Symposium held in February, 1960, devoted to a discussion of the most recent findings in the field of hemopoiesis: cell production and its regulation. The conference was limited essentially to those who are contributing to this field. In addition to 16 papers given by internationally known experts (including several from this country) in the field of kinetics of cellular proliferation, there is presented critical discussion following each paper and a general discussion at the end by all of the participants.

Studies on the kinetics and quantitative aspects of erythropoiesis, granulopoiesis, and lymphopoiesis; erythropoietin, and other factors in the control of hemopoiesis; radiation effects and blood cell production and balance; the function of the thymus and its cells, and the use of radioactive isotope tracers, particularly tritiated thymidine, in the study of hemopoietic cell proliferation are given in detail. Although much of the work presented represented studies in animals, there is some correlation, insofar as possible, with findings in normal, leukemic, anemic, and polycythemic states in humans.

This volume must be considered as an authoritative work of considerable value to the hematologist and others interested in cell formation, division, and maturation.

Milton H. Freedman, M.D.

GEORGIA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

A VERY SUCCESSFUL meeting of the Georgia Society of Ophthalmology and Otolaryngology was held March 2-4, 1961, at the General Oglethorpe Hotel, Wilmington Island, Savannah, Georgia.

Newly elected officers are: C. W. Whitworth, Gaines-

ville, president; P. Thomas Manchester, Atlanta, vice president, and James T. King, Atlanta, secretary.

Dates of future meetings will be printed in the *Journal* as soon as they are set.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County</i>	<i>Society</i>
Aldridge, Stanley P.	300 Boulevard, N.E. Atlanta 12	DE-2	Fulton	
Aronovitz, Gerson H.	1600 Clifton Rd. Atlanta 22	Service	Fulton	
Backerman, Ivan A.	35 Linden Ave. Atlanta 8	DE-2	Fulton	
Bland, James W., Jr.	1968 Peachtree Rd., N.W. Atlanta 9	DE-2	Fulton	
Boorstin, James B.	300 Boulevard, N.E. Atlanta 12	DE-2	Fulton	
Conley, Kenneth	304 N. Sage Toccoa	Active	Stephens	
Cook, William C., Jr.	125 Cliftwood Dr., N.E. Atlanta 5	Active	Fulton	
Hilbert, John F.	Emory University Hosp. Atlanta 22	DE-2	Fulton	
Johnson, R. Julian	35 Linden Ave., N.E. Atlanta 8	DE-2	Fulton	
Lescher, Charles F.	35 Linden Ave., N.E. Atlanta 8	DE-2	Fulton	
MacDonell, Frank S.	340 Boulevard, N.E. Atlanta 12	Active	Fulton	
McLean, Ross L.	69 Butler St., S.E. Atlanta 3	DE-2	Fulton	
Mitchell, William S., Jr.	35 Linden Ave., N.E. Atlanta 8	DE-2	Fulton	
Pittman, Frank Smith, III	80 Butler St., S.E. Atlanta 3	DE-2	Fulton	
Polesky, Reese E.	Emory University Hosp. Atlanta 22	DE-2	Fulton	
Riggsbee, John F.	Emory University Hosp. Atlanta 22	DE-2	Fulton	
Robinson, E. E., III	35 Linden Ave., N.E. Atlanta 8	DE-2	Fulton	
Smith, Douglas	478 Peachtree St., N.E. Atlanta 8	Active	Fulton	
Swain, Bruce	Clarkesville	Active	Habersham	
Whitnack, John D.	101 Third St., N.E. Atlanta 8	Active	Fulton	
Winter, Thorne S., III	80 Butler St., S.E. Atlanta 3	DE-2	Fulton	



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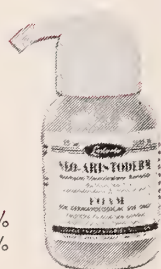
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Foam Neomycin —
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7.5 cc. and 15 cc.
push-button dispensers
Neat, not messy or sticky—
spreads readily without
irritation or burning—for
oozing, crusted, severely
inflamed and injured skin
or mucous membranes.

Each cc. contains:
Aristocort Triamcinolone Acetonide, 1 mg. . . . 0.1%
Neomycin Sulfate, 5 mg. 0.5%

Precautions: Contraindicated in herpes
simplex. Sensitivity reactions to
neomycin occasionally occur.



Aristoderm®

Foam 0.1% Triamcinolone
Acetonide

7.5 cc. and 15 cc.
push-button
dispensers

Precautions:
Contraindicated
in herpes simplex



Aristocort®

Cream 0.1% Triamcinolone
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Tubes of 5 and 15 Gm.

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HIGHLY ACTIVE WHEN DIRECTLY APPLIED TO SKIN LESIONS

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The anti-inflammatory and antipruritic efficacy of triamcinolone acetonide was shown by the prompt control of itching and resolution of affected areas. Cahn, M. M., and Levy, E. J.: A Comparison of Topical Corticosteroids: Triamcinolone Acetonide, Prednisolone, Fluorometholone, and Hydrocortisone.

Antibiotic Med. & Clin. Ther. 6:734 [Dec.] 1959.

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Ointment 0.1% Triamcinolone Acetonide

Tubes of 5 and 15 Gm.



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Eye-Ear Ointment 0.1%

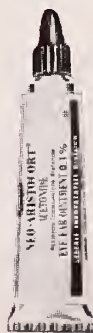
Neomycin—
Triamcinolone Acetonide

Tubes of ½ oz.

For inflammatory,
allergic, infective eye
and ear conditions

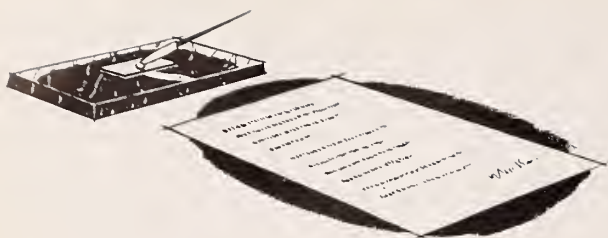
Each gram contains:
Aristocort Triamcinolone Acetonide . . . 1 mg.
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Precautions: Contraindicated in herpes simplex. Sensitivity reactions to neomycin occasionally occur.



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Precautions:
Contraindicated
in herpes simplex



abstracts by georgia authors

Letton, A. H., M.D. and Wilson, John P., M.D., 340 Boulevard, N.E., Atlanta 12, Georgia, "Clinical Applications of Blood Volume Determinations in Surgery," *Am. Surg.* 26:713-722 (Nov.) 1960.

It is 24 hours after a severe hemorrhage has occurred that the hemoglobin and hematocrit accurately shows the extent of hemorrhage. Within two to six hours following hemorrhage, hemodilution begins, gradually lowering the hemoglobin and hematocrit as the interstitial fluids enter the intravascular compartment. During the first 24 hour period after hemorrhage, its severity can be accurately determined only by using blood volume determinations. In the chronically ill patient, there may be changes in the volume which cannot be indicated by the hemoglobin and hematocrit. Until the blood volume is accurately known in the post hemorrhage or the chronically ill patient, the operative risk is really unknown.

Many methods have been suggested for calculating the expected or normal value of blood volume in an individual patient. Ninety-two volunteers were used. Their blood volume was determined and these statistics were substituted into the various formulas now available. In no instance did these measurements fit into the formula with satisfactory results. Therefore, a new formula had to be calculated, using ideal weight for height, taking into consideration, the size of frame of the individual. Once the muscle mass is known, the blood volume can be calculated. For the male, the formula expressed as $Y = ((1.09(X) - 25)(100))$ when Y is the blood volume and X is the kilograms weight corrected according to special table. The formula for the female was found to be $Y = ((1.68)(X) - 53.5)(100)$. Using these formulas, the estimated blood volume has been tested clinically and found satisfactory.

Redmond, W. B. and Cater, Jerome C., V.A. Hospital, Atlanta 19, Georgia, "A Bacteriophage Specific for *Mycobacterium Tuberculosis*, Varieties *Hominis* and *Bovis*," *Am. Rev. Respiratory Dis.* 82:781-786 (Dec.) 1960.

A bacteriophage, designed DS6A, active on human and bovine strains of tubercle bacilli was isolated from soil from a stockyard following enrichment with *Mycobacterium ATCC* No. 607 and *Mycobacterium tuberculosis* strain H37Rv. It is not active on saprophytic

or atypical mycobacteria. It has been tested on more than 500 strains. Plaques formed on bovine and BCG strains differ in appearance from plaques formed on human strains of tubercle bacilli. This difference may lead to a means of distinguishing between these two types.

Electron micrographs have shown the DS6A phage to be typical in morphology to other bacteriophages. It is resistant to 56° C. for 30 minutes, but is inactivated in 10 minutes at 70° C.

Antiserum, produced by injections of heavy suspensions of the phage into rabbits, inactivated 90 per cent of the phage in 30 minutes.

Other phages specific for the atypical strains are being sought for the purpose of providing a method of "phage-testing" of the mycobacteria.

Harrison, J. Harold, M.D. and Davalos, Pablo A., M.D., 490 Peachtree Street, N.E., Atlanta 8, Georgia, "Influence of Porosity on Synthetic Grafts," *Arch. Surg.* 82:8-13 (Jan.) 1961.

In a continuing study of various synthetic grafts in over 500 animals during the past five years, the importance of the role of porosity has become more apparent. To evaluate this factor, knitted and woven, crimped teflon and knitted, crimped dacron grafts with widely varying and measured porosities were inserted into the abdominal aortas of 175 dogs. Composite grafts 18 cm. in length with equal segments of varying porosities in rotating positions were inserted in thoracic aortas of 20 dogs to determine the influence in the same graft and animal. The most suitable of the teflon grafts inserted in 90 humans afforded some comparison.

Grafts that are too porous (some of which are being used clinically) bleed excessively. Though this could be controlled at the time of insertion, there was bleeding through the interstices in the postoperative period resulting in exsanguination or hematomas.

All non-porous grafts in both large and small vessels became occluded by thrombosis. Sixty-five per cent of the tightly woven grafts with a low porosity remained patent compared to 90 per cent in the more porous group. The healing time varied directly with the porosity, being much longer in the grafts with lower porosities.

Better results were obtained in humans; however, similar complications were encountered in sufficient

number to indicate that the experimental results are valid. The results in this study indicate that the ideal porosity is that just below the point of allowing excessive bleeding. Consistency in production of grafts with reproducible porosities is being accomplished and offers much in the replacement of small blood vessels, a problem that is far from being solved.

Pendergrast, William J., M.D.; Milmore, Benno K., M.D., and Marcus, Samuel C., B.S., 478 Peachtree Street, N.E., Atlanta 8, Georgia, "Thyroid Cancer and Thyrotoxicosis in the United States: Their Relation to Endemic Goiter," *J. Chronic Dis.* 13:22-38 (Jan.) 1961.

Clinical evidence suggests that goiter predisposes to thyroid cancer and to thyrotoxicosis. In this article, an attempt was made to prove this relationship by defining the goiter areas in the United States and demonstrating the dramatic decrease in goiter since the use of iodized salt began.

These observations demonstrated a close relationship between goiter and thyrotoxicosis and a rapid fall in death rates from thyrotoxicosis paralleling the fall in goiter incidence. The decrease in mortality and morbidity seem to be primarily due to goiter prophylaxis from iodized salt.

Thyroid cancer mortality showed no such relationship. During the years available for study, thyroid cancer mortality has slightly increased. Thyroid cancer does not seem to occur more frequently in goiterous areas and thyroid cancer mortality has not decreased with a decrease in goiter.

Pritchard, William Lee, M.D., Medical College of Georgia, Augusta, Georgia, "Selective Head Cooling in the Dog," *Neurology* 11:77-82 (Jan.) 1961.

Previous studies demonstrate the facility of brain cooling by extracorporeal perfusion technique. In this study selective head cooling was accomplished by establishing a second perfusion unit to rewarm the cold jugular blood returning from the head before it reentered the general circulation.

Using 23 heparinized dogs, carotid outflow was shunted through a cooling system and then pumped into the distal carotid artery to the head. Jugular blood passed by gravity flow through a rewarming system and was then pumped to the superior vena cava.

In dogs subjected to carotid cooling

only, the brain temperatures were lowered to an average of 17° C. during perfusion times ranging from 18 to 53 minutes. In animals subjected to carotid cooling plus jugular rewarming, the lowest brain temperatures averaged 9.5° C. for perfusion periods averaging two hours 43 minutes.

Ten dogs died due to explained causes other than hypothermia per se. Thirteen survivors were observed for periods of four to ten weeks revealing no neurological deficits. Pathologic studies revealed no brain damage.

The rapidity of this method of brain cooling may lend itself to treatment of traumatic and anoxic brain injuries. Control of brain circulation is inherent in this technique and may be an effective adjunct to surgery of intracranial lesions.

Sheldon, Walter H., M.D., Baltimore, Md. and Bauer, Heinz, M.D., Emory University Hospital, Atlanta 22, Georgia, "Tissue Mast Cells and Acute Inflammation in Experimental Cutaneous Mucormycosis of Normal, 48/80-Treated, and Diabetic Rats," *J. Exp. Med.* 112:1069-1084 (Dec.) 1960.

The role of the tissue mast cells in relation to the acute inflammatory reaction to experimental cutaneous mucormycosis was studied histologically in normal rats, in animals whose tissue mast cells had been depleted of their

cytoplasmic granules prior to infection by the administration of compound 48/80, and in others in whom acute alloxan diabetes with acidosis had been produced before injection of the fungus.

It is concluded that a function of the tissue mast cells in the normal rat is the rapid initiation of acute inflammation at the site of injury and that degranulation of these cells prior to infection through pretreatment with compound 48/80 somewhat delays the inflammatory response and, therefore, slightly diminishes host resistance. Furthermore, a severe metabolic disorder, such as acute alloxan diabetes with acidosis, inhibits the normal function of the tissue mast cells, delays and decreases inflammation, and in this manner contributes to the greatly increased susceptibility of the host to infection.

Thomas, Wesley C., M.D., 1717 Reynolds Street, Brunswick, Georgia, "Submucous Resection of the Nasal Septum," *South. M. J.* (Nov.) 1960.

The purpose of this paper is to point out the value of the submucous resection and to introduce a new method of using anesthesia for this operation. Rhinologists who are disinclined to advise this operation are probably influenced by the difficulties encountered

with the universally used local anesthesia.

Etiology is discussed briefly but this is unimportant to the surgeon as compared to the symptoms he is called on to relieve. Headache, nasal obstruction, postnasal discharge, and frequent re-activations of a nasal infection are the most important symptoms.

Local anesthesia is accompanied by toxic effects of the drugs used and also by emotional agitation caused by the operative work. The method which I am offering is a combination of local and intravenous. For some reason, which cannot be explained at present, the local must be given first then the intravenous thiopental and succinylcholine is given. For the local application and for the surgery, the patient is in the semireclining position, and for the intravenous, the recumbent position is used.

The classical submucous is done in most cases, but to get best results in all cases, postoperative care must extend over a period of several weeks. The enlarged turbinates must be reduced by displacement, sclerosing fluid, cautery or surgery as is required.

Of 28 cases contacted for report, 13 were relieved of symptoms entirely, 13 were improved, and two were unimproved. One of the cases, which was unimproved, has not had the after care as was advised and should not be included in the list.

U.S. DEATH RATE CUT IN HALF SINCE 1900

MORTALITY RATES, THE BEST available measure of a nation's health level, dropped by almost one-half in this country from 1900 to 1960, Health Information Foundation reported recently.

In the February issue of *Progress in Health Services*, its monthly statistical bulletin, the Foundation reviewed the main trends in U.S. mortality on the basis of published and unpublished data of the National Office of Vital Statistics.

In 1900, the death rate in this country was 17.2 per 1,000 persons. The 1960 rate (estimated by the Foundation research staff) was only 9.4 per 1,000—a reduction of about 45 per cent.

Moreover, when the crude mortality rates were adjusted to a standard population (the 1940 U.S. population) the estimated 1960 death rate was only 7.7 per 1,000 population—less than one-half the comparable 1900 rate.

Although mortality declined for each age group in the nation's population, the largest relative gains took place at the younger ages, especially during childhood. Between 1900 and 1959 the mortality rate dropped by 82 per cent during infancy and by 94 per cent at ages one through four. The comparable declines at other age groups were: ages five through nine, 89 per cent; ages 35-44, 72 per cent; ages 65-74, 28 per cent; ages 85 and over, 21 per cent.

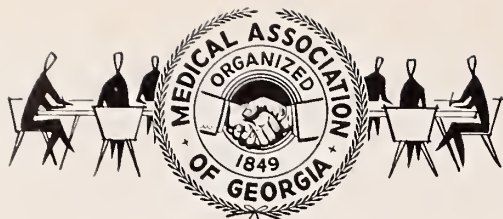
Death rates have dropped more rapidly for females

than for males since the turn of the century, the Foundation added. In 1900 the death rate for females was 16.5 per 1,000; by 1959 it had gone down to 8.0, a decline of 51.5 per cent. For males the corresponding drop was from 17.9 to 10.9 per 1,000, or 39.1 per cent.

Unlike the widening sex differential, the mortality differential between the white and the non-white populations has narrowed. Thus in 1900 the death rate for non-whites exceeded that for whites by 47 per cent. But by 1959 the rate for non-whites (9.9) topped that for whites (9.4) by only 5 per cent.

One of the main reasons behind the decline in mortality rates, according to the Foundation, has been the fact that the major communicable diseases—leading causes of death in 1900—have been largely brought under control. During the last 60 years the death rate for influenza and pneumonia, for example, has dropped by 86 per cent and that for tuberculosis by 98 per cent.

As George Bugbee, Foundation President, pointed out, "Gains in fighting infectious diseases have centered around the early and middle years. Children do not die in epidemics as they once did. The benefits have been almost as great to persons in the childbearing and chief work years. These are precious attainments, leading to more stable family life and a more active work force."



the association

DEATHS

OSWELL T. MALONE, of Atlanta, died February 24 in a private hospital at the age of 70.

Born in Fayette County, he was graduated from Emory University School of Medicine in 1915 and later studied at Yale University. Dr. Malone practiced medicine in Fayetteville before moving to Atlanta about 30 years ago.

Dr. Malone served on the staff at Crawford W. Long Memorial Hospital many years, and served in the Medical Corps in World War I and in the Selective Service office in Atlanta during World War II.

He was a member of the Second Ponce de Leon Baptist Church, the American Medical Association, the Fulton County Medical Society, and the Emory Alumni Association.

Survivors include his wife, the former Henrietta Fisk of Atlanta; a daughter, Mrs. Raymond Del Rosso, Baltimore, Md.; two sons, William T. and George H. Malone, both of Los Angeles, Calif.; a sister, Mrs. Palestine Malone, and two grandchildren.

SOCIETIES

The **BIBB COUNTY MEDICAL SOCIETY** met in March at the Pinebrook Inn. The program was presented by Claude Pennington and included a color movie of middle ear surgery taken through the operating microscope.

"Excessive" speeding by ambulances was the target of a recent resolution passed by the **COBB COUNTY MEDICAL SOCIETY** and the Kennestone Hospital medical staff.

Specifically told by the **COLQUITT COUNTY MEDICAL SOCIETY** that excessive speed on emergency calls "is risking and claiming more lives than can be saved," Moultrie police and ambulance operators joined in a program to "proceed with caution" when answering calls and taking patients to hospitals.

Scores of southwest Georgia doctors attended the fourth annual Southwest Georgia Medical Seminar held at the New Albany Hotel, sponsored by the **DOUGH-**

ERTY COUNTY MEDICAL SOCIETY in conjunction with the American Academy of General Practice.

The **FRANKLIN-HART-ELBERT MEDICAL SOCIETY** met in March at the Elberton Country Club with Dr. Martha Dull, Chief Resident of Obstetrics and Gynecology at Talmadge Memorial Hospital, giving a talk on pre- and post-partum hemorrhage. The next meeting is planned for June 7.

Closed-circuit telecasts from Grady Memorial Hospital highlighted the Atlanta Graduate Medical Assembly held in February. The assembly is a postgraduate training seminar for practicing physicians and surgeons and is sponsored annually by the **FULTON COUNTY MEDICAL SOCIETY**.

The regular meeting of the **GEORGIA MEDICAL SOCIETY** was held in March with Frederick P. Zuspan, Professor of Obstetrics and Gynecology at the Medical College of Georgia as guest speaker.

Bartley Wilbanks has been elected president of the **HABERSHAM COUNTY MEDICAL SOCIETY**. Other officers chosen at the election meeting held recently were: Austin Walters, vice president, and Don Fahrback, secretary-treasurer.

The **HALL COUNTY MEDICAL SOCIETY**, at its February meeting, heard an Atlanta pathologist, John T. Godwin, discuss the "Clinical Application of Radioactive Isotopes."

The regular monthly meeting of the **MUSCOGEE COUNTY MEDICAL SOCIETY** was held in February at the Standard Club. The guest speaker was Dr. Alton Ochsner, Jr., of New Orleans, who spoke on "Management of Vascular Insufficiency to the Lower Limbs."

The **RICHMOND COUNTY MEDICAL SOCIETY** held its regular monthly meeting recently at the First Federal Building; Dr. W. G. Rice, of the Medical College of Georgia, was guest speaker.

The quarterly meeting of the **THOMAS-BROOKS MEDICAL SOCIETY** was held at the Quitman Country Club, in Quitman, the middle of March. The program was presented by Dr. Gerold Schiebler, Associate Professor, University of Florida Medical School, Gainesville, who spoke on "Surgery in Pediatric Cardiology."

The Medical Association of Georgia approved a statewide program of "Stroke Rehabilitation" conducted jointly by the Georgia Heart Association and the Georgia Department of Public Health. The **WARE COUNTY MEDICAL SOCIETY** approved this program and with the Ware County Health Department sponsored a seminar recently.

SPECIAL

THE GEORGIA MEDICAL SOCIETY recently published Vol. 1, No. 1 of the newly established *Bulletin of the Georgia Medical Society*. The editor is M. G. Robertson.

The *Bulletin* carries all the Society's news and news of the Savannah area that would be of interest to the Society.

Accepted warmly, not only by the members of the Society, but also by many physicians over the State that have had the privilege of reading it, the *Bulletin* is certainly a credit to its staff and members of the Georgia Medical Society.

PERSONALS

First District

The Medical College of Georgia recently sponsored a postgraduate course on "Management of Patients with vascular Disease. Among the faculty was CURTIS HAMES, of Claxton.

One of the Georgia physicians featured on a program of the Georgia Association of Plaintiffs' Trial Attorneys held in Atlanta recently was HARRY E. ROLLINGS, of Savannah.

KATRINE HAWKINS, Sylvania, recently took a postgraduate course at the Medical College of Georgia, Augusta, on vascular diseases.

In another move toward providing the people of Candler County more complete medical coverage at home, the Hospital Board announced recently that FRANK ROBBINS, of Vidalia, has accepted the position of consulting surgeon on the staff of the Candler County Hospital.

Second District

J. DEAN PASCHAL, Albany, presented an interesting film "Shyness of Children" to the February meeting of the Morningside Parent-Teacher Association.

DR. and MRS. HARRY W. PRATER, formerly of Jefferson, have moved to Blakely, where Dr. Prater is engaged in the practice of general medicine.

Three aspects of heart and cardiovascular diseases were discussed by OSCAR M. MIMS, Thomasville, president of the Thomas-Brooks Medical Society, at a meeting of the Society's Auxiliary recently.

Third District

ROBERT A. COLLINS, JR., of Americus, has been inducted as a new Fellow of the American College of Surgeons.

During the 34th annual Georgia Conference on Social Welfare held in Savannah in February, LEONARD T. MAHOLICK, Columbus, conducted an institute on mental illness.

Fourth District

After serving as Fayette County physician for some 30 years, T. J. BUSEY, Fayetteville, has retired from that position.

Fifth District

R. BRUCE LOGUE, Atlanta, recently addressed the Medical and Surgical Symposium of Watts Hospital, in Durham, N. C.

RIVES CHALMERS, of Atlanta, recently spoke at the 34th annual Georgia Conference on Social Welfare held in Savannah.

Two of the four Georgia physicians featured on the program of the Georgia Association of Plaintiffs' Trial Attorneys held in Atlanta recently were CHARLES S. JONES and EDWARD D. REISMAN, both of Atlanta.

JOHN S. ATWATER, of Atlanta, was among speakers at the Georgia Nutrition Council's annual meeting held recently at Emory University.

The controversial subject of "Medical Care for the Aged" was discussed by a panel of experts at the February Forum of the Cathedral Club of Christ the King Cathedral, in Atlanta. Participating on the panel was JOHN T. MAULDIN, chairman of the Georgia delegation to the Washington Conference on Aid to the Aged.

Sixth District

No news submitted.

Seventh District

Approximately 1,175 surgeons were inducted as new Fellows of the American College of Surgeons in cap-and-gown ceremonies closing the annual five-day Clinical Congress of the world's largest organization of surgeons, in San Francisco recently. Among those receiving the distinction was CALVIN L. EDWARDS, of Dalton.

Eighth District

Y. F. CARTER, JR., Nashville, was a participant recently in a postgraduate workshop at the Medical College of Georgia, Augusta, concerned with medical problems posed by the newborn infant.

Ninth District

W. BRUCE SCHAEFER, of Toccoa, appeared on a panel during a meeting of the Georgia Association of Plaintiffs' Trial Attorneys held in Atlanta recently.

Tenth District

ROBERT G. ELLISON, of Augusta, was recently guest speaker at the regular meeting of the Glascock County Parent-Teacher Association.

The Medical College of Georgia recently sponsored a postgraduate course on "Management of Patients with Vascular Disease" under the supervision of J. EDWIN WOOD, III, Augusta, Director of the Georgia Heart Association Laboratory for Cardiovascular Research in Talmadge Memorial Hospital.

Executive Committee of MAG Council Meeting

THE FEBRUARY MEETING of the Medical Association of Georgia Executive Committee of Council was called to order by Chairman Milford B. Hatcher at 10:40 A.M., on February 19, 1961 at the MAG Headquarters Building, Atlanta, Georgia.

The members of the Committee present were: Milford B.

Hatcher, Macon, President and Chairman; Fred H. Simonton, Chickamauga, President-Elect; J. G. McDaniel, Atlanta, Chairman of Council; John T. Mauldin, Atlanta, Secretary; Luther H. Wolff, Columbus, Past President, and Virgil B. Williams, Griffin, Chairman of Finance. Also present were C. Raymond Arp, Atlanta, Treasurer; Eustace A. Allen, Atlanta, AMA Delegate; Mr. J. F. Drapalik, MAG Auditor; Mr. Milton D. Krueger, Executive Secretary; Mr. James M. Moffett, Assistant Executive Secretary; Miss Thelma Franklin, and Mrs. Catherine Wooten, Headquarters Office.

Chairman Hatcher officially welcomed Mr. Moffett to the Headquarters Staff and acknowledged the presence of Doctors Arp and Allen.

The minutes of the December 11 and January 22 Executive Committee meetings were read by Mr. Krueger. There being no corrections, on motion duly made and seconded, the minutes were approved as read.

Relative Value Study Committee

The appointment of this committee was discussed by Dr. Hatcher and recommendations were made as follows: Harry D. Pinson, Augusta, Chairman; Robert E. Cato, Macon; David R. Thomas, Augusta; E. C. Whatley, Reynolds; Remer Y. Clark, Marietta, and Joseph E. Griffith, Marietta, with Mr. Frantz Lipsey, Medicare Administrator, to act as Secretary. There was general discussion following these recommendations. On motion duly made and seconded it was voted to accept these recommendations as members of the committee, and it was requested that a preliminary report be given to Council at the May 6, 1961 meeting.

Treasurer's Report

C. Raymond Arp, Treasurer, reported on the MAG income and expenditures to date. On motion (Wolff-McDaniel) it was voted to accept the report with suggested changes in format.

Building Depreciation

Mr. Drapalik suggested that 12-15 years would be a reasonable estimate on the depreciation for the building. It was recommended that a 15-year depreciation on the building be taken and five years on the parking lot and air conditioner. The components of the building are to be worked out by the accountant. On motion duly made and seconded it was voted to accept the above recommendations.

Mortgage Payment

Secretary Mauldin discussed the payment of the building mortgage. On motion (McDaniel-Simonton) it was voted to pay an additional \$5,000.00 on the mortgage and the remainder of last year's (1960) excess funds to be put in the contingent fund and shown on this year's budget.

Industrial Health Committee Report

Mr. Krueger gave the report that Dr. Peterson has been unable to obtain the information regarding State Pre-employment Physical Examination Recommendations and Workman's Compensation Negotiation but would have it by the time of the next meeting.

Meriwether-Harris County Society Problem

Mr. Krueger gave the status of this problem at the present time. There followed general discussion regarding what action MAG should take on this matter. On motion (Wolff-Williams) it was voted to have the Secretary contact the State Board of Medical Examiners with the request that they take some positive action.

Medical Examining Board Unauthorized Medical Practice Cases

Secretary Mauldin recommended that \$1500.00 be taken from Contingent Fund to be budgeted for the investigation of these cases. On motion duly made and seconded it was voted to recommend to Council for approval.

National Legislative Activity

Mr. Krueger and Mr. Moffett gave a report on the following:

(a) *State Activity*: A Breakfast Meeting was held on February 17, 1961 for the purpose of acquainting certain officials of state organizations with our position regarding the Kennedy bill (HR 4222) and to solicit their help in promoting the Kerr-Mills Bill and it suggested that local societies be informed how they may have such meetings. (b) *Washington Trip*: On motion duly made and seconded it was voted to appoint John T. Mauldin, Chairman and John A. Bell, T. A. Peterson, Fred H. Simonton, and Mr. James M. Moffett as members of a committee to make this trip; (c) *AMA Legislative Keyman Appointment*: It was recommended that President Hatcher designate the three physicians as requested by AMA, and they are as follows: John A. Bell, Eustace A. Allen, and J. Frank Walker; (d) *AMA Legislative Conference, March 18-19, Chicago*: On motion duly made and seconded it was voted to have the President select those to attend this meeting. The AMA is to pay for three physicians and MAG to pay for the staff. Those designated to make the trip are: President Milford B. Hatcher, John T. Mauldin, Eustace A. Allen, Mr. Krueger, and Mr. Moffett.

Dr. Wolff suggested that at the time of the Washington trip, the Social Security bill to bring physicians under Social Security be discussed with Senators Russell and Talmadge, and that MAG go on record as opposing this bill.

State Legislative Activity

Mr. Moffett gave Executive Committee information on the bills before the Georgia Legislature and their progress.

Raiford Letter

Dr. Allen read a letter from Morgan B. Raiford regarding poor public relations between AMA and the public with reference to recent television programs. There was general discussion about the possibility of introducing a resolution at the next AMA meeting to get some positive action in this regard. On motion duly made and seconded it was voted to have Doctors Hatcher, McDaniel, and Allen draw up a resolution to present to the Council at the next meeting. It was also suggested that copies of a letter Dr. McDaniel wrote to the Chairman of the AMA Board of Trustees and Dr. Raiford's letter be sent to all members of the Executive Committee.

AMA Regional Medicolegal Conference

Mr. Krueger presented a written communication from Mr. Joseph Stetler, Director of the Socio-Economic Division of the American Medical Association. This letter invited the Association to send representatives to a Medilegal Conference to be held April 14-15, 1961 in Louisville, Kentucky under the auspices of the AMA. It was recommended that Secretary John T. Mauldin and Executive Secretary, Mr. Milton D. Krueger, attend this meeting as representatives of the Association. Per prior minutes of the Executive Committee meeting of Council on this same matter, Executive Committee advised that Mr. Gene Hope of the St. Paul Mercury Company and Mr. Emerson Gardner, of Moise, Post and Gardner, could also attend this meeting as part of the Georgia Delegation at their own expense.

Fraternal Delegates to Other State Association Annual Sessions

Mr. Krueger presented communications from the State Medical Association of Alabama and Florida State Medical Association inviting representatives of MAG to attend their annual sessions. On motion duly made and seconded it was voted to ask President Hatcher to so appoint representatives to attend these annual meetings of sister state associations as representatives of MAG.

SAMA Medical College of Georgia Request

A communication was presented from the President of the Student American Medical Association Chapter at the Medical College of Georgia. This letter requested funds for the attendance of delegate representatives from the SAMA Chapter at the Medical College. On motion duly made and seconded it was voted that the \$250.00 previously budgeted for this purpose be made available to these representatives to attend this SAMA May meeting in Chicago. Mr. Krueger was instructed to write the SAMA Medical College of Georgia Chapter President and so inform him of the availability of these funds.

Office Correspondence

Secretary John T. Mauldin read a thank-you letter from Dr. Raymond Arp for sentiment expressed by the Medical Asso-

ciation of Georgia on the recent passing of his mother. Dr. Mauldin then presented a letter from the "Medic-Alert Foundation" which was deferred until the next meeting of the Executive Committee for consideration and action.

Headquarters Office Report

Mr. M. D. Krueger, Executive Secretary, reported on the recent activity of the Headquarters Office and gave an indication of the following months activity as planned by committee chairmen, etc. At this time Mr. James Moffett, Assistant Executive Secretary, was formally introduced to the members of the Executive Committee and President Hatcher welcomed him as a new employee of the Association.

Medical College of Georgia Education Resolution

After due discussion of a resolution passed by MAG Council at the December 11 meeting concerning Medical Education in the State of Georgia it was moved that a copy of this resolution be sent to each of the ten district societies and that some notice of the resolution be carried in a future issue of the *Journal* either as a separate sheet or as a President's Page or editorial subject.

Other Business

Executive Committee of Council set the date and site of the March Council meeting and Executive Committee meeting for March 25-26, 1961, Atlanta, Georgia.

There being no further business the meeting was adjourned at 3:30 P.M.

DR. JABEZ JONES — 1873-1960

WITH THE PASSING of Dr. Jabez Jones December 30, 1960, The Georgia Medical Society lost one of its most highly esteemed and outstanding members. During his many years of practice, Dr. Jones enjoyed a justly deserved reputation as a very fine diagnostician and surgeon.

He was a man of high integrity and he expected the same from the younger men who were privileged to come under his sphere of influence. To him the oath of Hippocrates was not just a plaque to adorn the wall of his office; it was a creed to live by in his professional ministrations. There were no shades of gray in his make-up; it was either right or it was wrong; there was no compromise.

He was a man of varied interests; a perceptive student of the newer concepts in the field of medicine; he enjoyed good books; he was an independent thinker concerning political and civic matters, and did not hesitate to support any cause that he deemed worthy. He was an ardent fisherman and even after his retirement he spent many hours enjoying this relaxing sport. He appreciated a good story and would laugh with great gusto if it appealed to his sense of humor. He was a man of few words but when he expressed an opinion it carried authority. His letters were classics in brevity.

He was quite a mechanical genius and had many surgical instruments fabricated to his own design. He devised instruments for formulating autogenous bone bolts and screws during orthopedic surgery, and at a time before similar appliances made of beef bones became available. If he had taken the trouble to publicize this one device, he would have been nationally famous.

Dr. Jones was born in Madison, South Carolina, October 10, 1873. He received his M.D. degree from Atlanta Medical College, which is now Emory, in the class of 1898. He served an internship in Grady Hos-

pital and chose Savannah as the place for his active practice.

He was President of this Society in 1907 and 1908 and became a life member in 1949. He was interested in various charitable institutions in this community but his greatest dedication was to the Telfair Hospital, where he served as Medical Director for some 39 years. During his reign, the Telfair had its greatest period of usefulness to the community and the surrounding counties. It was considered quite an honor to be chosen to serve under him on the active staff.

His last illness covered a span of several years, but it did not prevent him from continuing to enjoy his fishing in Florida, and from still being an entertaining conversationalist. He bore the trials of his illness with typical fortitude. One of his few remarks concerning it was that he had been fighting conditions of a similar nature all his life and now it had caught up with him.

Again may it be stated that our Society has lost one of its members who has had a great influence for good in the field of medicine. It was the happy lot of our late associate to reach more than the scriptural span of life and seeing the fruits of his labors in his chosen profession.

With a sense of great loss to the community and to the medical profession is mingled a deep sympathy for the members of his family.

Be it therefore resolved, that this memorial be sent to the family of Dr. Jabez Jones and a copy spread upon the minutes of this meeting.

*E. C. Demmond, Chairman
Committee on Resolutions
C. F. Holton
J. K. Quattlebaum, Sr.*

A RESOLUTION IN MEMORIAM TO WILLIAM L. COOKE

"MR. PRESIDENT, AND members of the Muscogee County Medical Society:

"I have been asked to present a letter in memory of one of our most famous members, Dr. W. L. Cooke.

"As many of you know, it was my privilege to work with Dr. Cooke for several years, and it is my wish to present to you something of this man and his devotion to his work and the hospital, rather than a formal memoriam. This would be what Dr. Cooke would want.

"Dr. Cooke was born and raised in Virginia, and graduated from the Medical College of Virginia in 1904, served his internship in Richmond and New York, and began his practice in Columbus in 1906.

"It would be hard for the average physician of today to undertake the devotion and loyalty given to the profession by Dr. Cooke. He was a master surgeon of unusual abilities as a diagnostician and technician in the art of surgery, especially when one remembers that his day was before we had the advantages of present day aids in diagnosis. I recall a male patient one time who had a McBurney scar and gave a history of having had an appendectomy. In spite of this, Dr. Cooke made a diagnosis of acute appendicitis. He said to me, 'Dr.

Gilliam, in my mind, this man has an acute appendix. He obviously has had an operation for an appendix. In my opinion, he still has his appendix, and therefore, his surgeon was unable to find it, and if he couldn't find it, it must be in an abnormal position.' He made an incision posteriorly and cut down on and removed a gangrenous retro-cecal appendix. I give this as an example of his judgment and his confidence in his judgment.

"Dr. Cooke began his surgical career by operating in the home in the surrounding country and towns of Columbus before Columbus had hospital facilities. He used to work all day in his office, then drive to one of the surrounding towns and operate at night, and be back in his office for work the next day. It was my privilege to accompany him and assist in numerous operations in the home. He was outstandingly successful in his results.

"I would like to mention Dr. Cooke's deep religious convictions. He loved his religion and his church and he lived it. In all my years with Dr. Cooke, I never once saw him refuse his services to a patient because they could not pay him for this service. I have so many times heard him say, 'The Lord gave me my ability and it is my duty to help anyone that needs me.'

"So, in memory of his devotion to his religion, his loyalty to his profession, and to his patients, I move that this letter be recorded in the records of the Muscogee County Medical Society, and that a copy be read to the Medical Center Staff at its next meeting and that a copy be sent to his widow, Mrs. W. L. Cooke."

O. D. Gilliam, M.D.

LEE HOWARD, M.D. — 1888-1960

ON THE EARLY MORNING of December 14, 1960, Dr. Lee Howard died suddenly at his home in Pin Point, near Savannah. It was evidence of his deep interest in the activities of the Georgia Medical Society that on the previous evening he had attended its meeting.

The deceased was born at Macon, Georgia, on September 10, 1888. After graduating with an A.B. degree from Mercer University in 1909, he attended Johns Hopkins Medical School from which he obtained his M.D. in 1913. Dr. Howard commenced the practice of medicine at Waycross in 1914. The following year he moved to Savannah where he interned at the Telfair Hospital during the next two years. He later did post-

graduate study in pathology at Johns Hopkins. During World War I, he served as a medical officer.

Dr. Howard joined the Georgia Medical Society in 1915. From that time until his death he was active in its affairs, serving as its President, 1930-31 and as a trustee for many years. In 1935 he was President of the First District Medical Society. From 1946-52 he was councillor to the Medical Association of Georgia. He served as President of the State Association in 1959.

As resident in the Telfair Hospital, Dr. Howard organized the first clinical laboratory in this area. He subsequently established laboratories in other hospitals at Savannah and acted as their pathologist. He succeeded the late Dr. William H. Myers as director of the District State Aid Cancer Work and was one of the founders of the Savannah Tumor Clinic, serving several years as a director. Dr. Howard headed the Howard Clinical Laboratories of Savannah, the laboratory at Statesboro and also in Swainsboro. He was a Fellow of the American College of Physicians; the American Society of Clinical Pathologists, and of the College of American Pathologists. He was a charter member of the Savannah Kiwanis Club.

Dr. Howard married Miss May duBignon Stiles of Brunswick, a union of which four sons and a daughter were born. He was deeply devoted to his family and his home. Among his hobbies were the cultivation of flowers and vegetables; he was generous indeed in sharing these with his friends. His capacity for friendship was deep. A man of tender sensibilities, his heart shared equally in the griefs as well as the pleasures of his friends. He was an ardent hunter and fisherman and transmitted this love of the outdoors to his children. It was rare that he went afield or astream without taking one or more of them with him. As a man, Lee Howard always had much to offer to friends and acquaintances and by the same token he expected the same. He was easy going, slow, and deliberate.

The deceased is survived by his widow and by four sons, John C., Lee, Jr., and Robert M., all physicians; Harry D. Howard, and by a daughter, Mrs. May Howard Zipperer.

BE IT RESOLVED, that in the death of Lee Howard, the medical profession in Georgia, and the Georgia Medical Society, particularly, have sustained the loss of a most valued and esteemed member, and his community and State the loss of a highly respected citizen who took a deep interest in public and civic affairs.

BE IT FURTHER RESOLVED, that a copy of this memorial be incorporated in the minutes of this meeting as a permanent reminder of the high character and attainments of the late Dr. Lee Howard, and that a copy be sent to his widow.

This February 14, 1961.

*John L. Elliott, M.D.
T. A. Peterson, M.D.
Robert Drane, M.D., Chairman*

CONTINUING POSTGRADUATE EDUCATION PROGRAMS

TUESDAY, MARCH 7, THE Toccoa Clinic sponsored the third in a series of Continuing Postgraduate Education programs. Dr. John H. Reed, Gainesville ophthalmolo-

gist, spent the afternoon at the Clinic discussing interesting and problem cases, showing slides, and holding an informal question-answer discussion.

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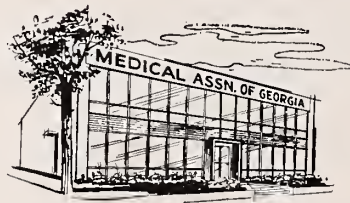
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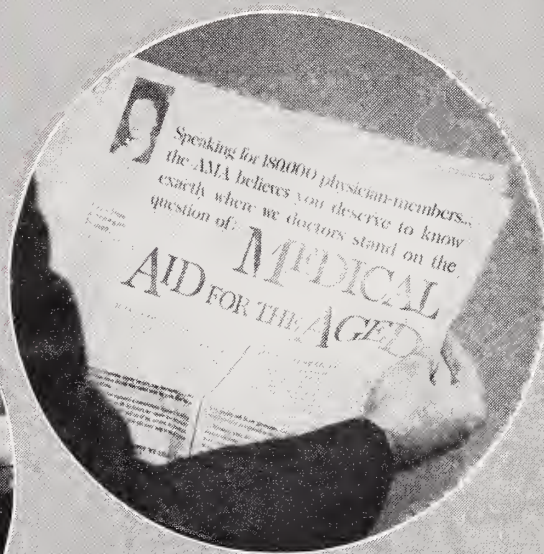
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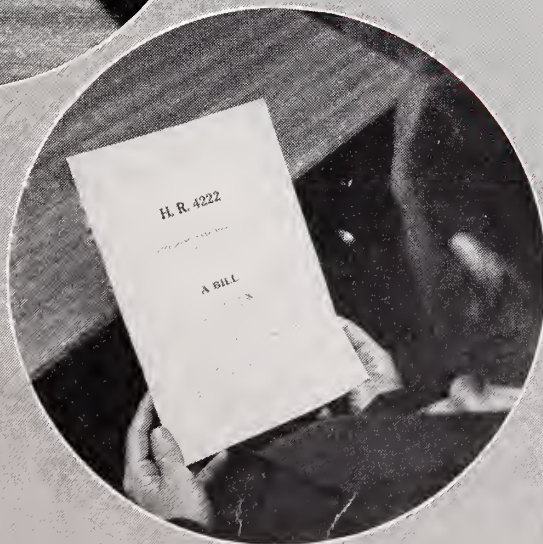
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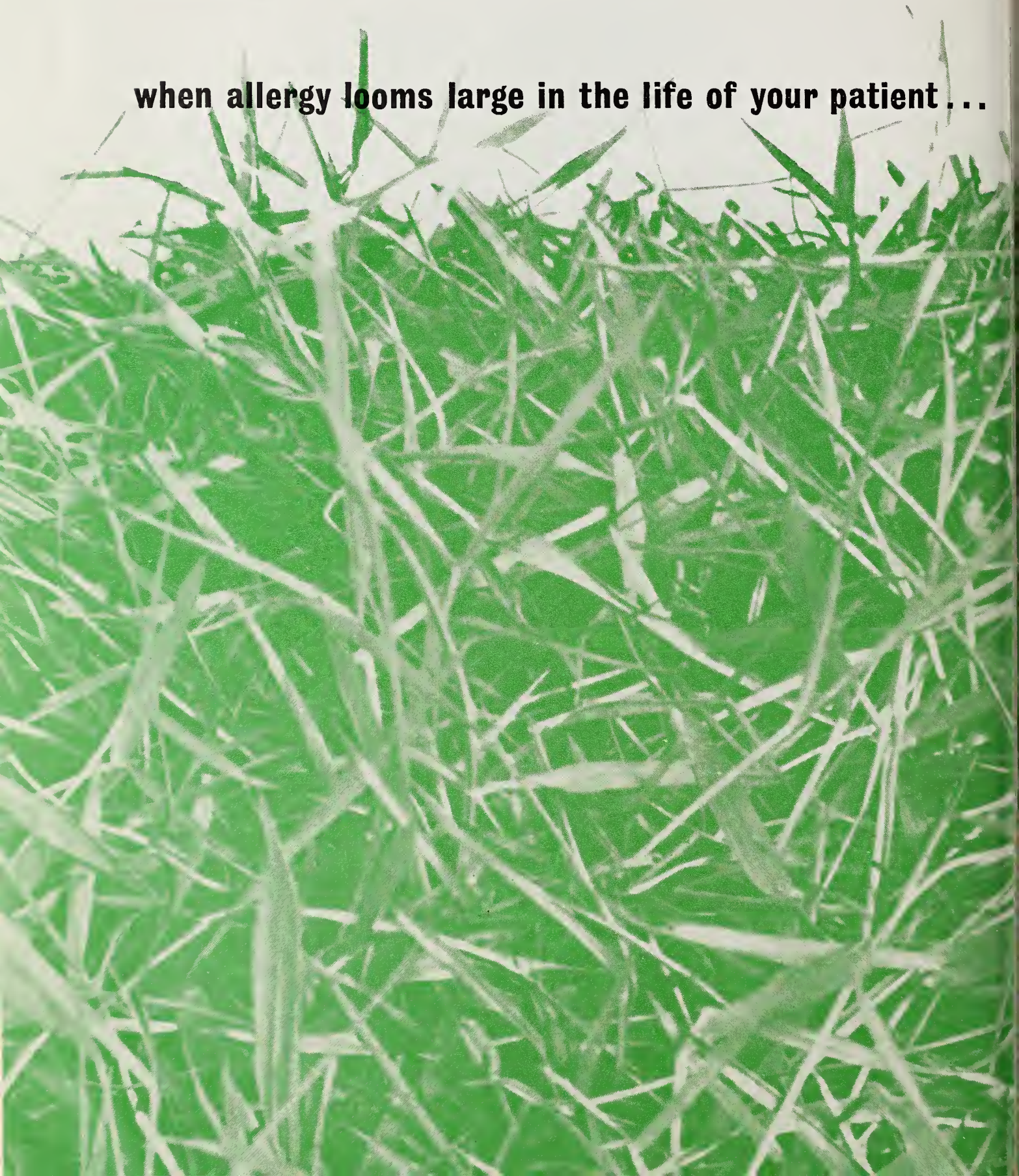


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THE ASSOCIATION FUTURE 1961-62

Fred H. Simonton, M.D., *Chickamauga, President,*
Medical Association of Georgia

PRESIDENT HATCHER, MEMBERS of the Medical Association of Georgia, and guests:

In assuming the presidency of this association, I am constrained to give voice to some mixed feelings—feelings of gratitude on the one hand for the honor you have bestowed upon me, and on the other hand, a feeling of fear and trepidation that I will not be able to match the record and accomplishments of my able predecessors in this office. With humble recognition of the magnitude of the tasks which lie ahead, I shall promise to expend all my energies and to utilize whatever abilities I may possess to further the aims and the best interests of this organization.

The year that lies ahead will no doubt be one of crises and challenges, just as the year through which we have just passed. We should remember that these problems are not limited to the world of free medicine alone. This is an age of change and ferment throughout all the various aspects of democratic society—political, social, economic, and technological. The entire world of freedom is being challenged as it has never been challenged before. Medical practice, as we have known it, will not survive unless our political system and our economic system survive. All are each and together based upon the premise that man, as a human being, is the most important thing under the sun, and that basically, no institution is secure against corruption which does not try to recognize man's worth and to give him the dignity that he deserves. The philosopher, the business man, the statesman, and the economist each has a problem similar to ours. It is a problem of meeting the demands of the masses of

the people who today are no longer willing to be denied the full life which they know can be provided by the economy of abundance which they see



FRED H. SIMONTON
President 1961-62

around them. In so far as this relates to the medical profession, this demand is for basic and necessary services which we can provide. It is a demand that they be given equal access with all other men to the advanced technology of our research scientists. It is a demand that they be able to obtain reasonable

Presented at the 107th Annual Session of the Medical Association of Georgia, May 8, 1961, Atlanta, Georgia.

hospitalization through a long illness without suffering the loss of the savings of a lifetime and their children's heritage, including their right to a college education. In brief—they are demanding of their government that it organize and provide them with some form of assistance in these matters. The paramount question, which the medical profession must face in the immediate future, is *not* that of preventing this growing tide of sentiment for government support for medical assistance. I tell you frankly that we cannot dodge this issue. It is inevitable—it is bound to come in one form or another, whether we maintain our democratic way of life or whether we lose the struggle to our communist enemies. Indeed, it is already here. It is both vain and arrogant for us to think that we can stop this trend in medicine when it has permeated every other aspect of modern living throughout the free world. Then let us not delude ourselves. It serves no good purpose to give this movement the label of Socialism or socialized medicine. Others are just as good as we are in manufacturing labels and in a contest of name-calling, we might well come out second best. For some time now, the proponents of medical assistance plans are calling the American Medical Association “the most powerful and reactionary labor union in the world.” Our problem then is to take hold of this issue which is already upon us, clarify our stand, and offer the public a comprehensive and workable plan. This is the only constructive manner by which we can render a lasting service to our patients, to our noble profession, and to our great country.

I want to outline to you in simple terms what I shall call the philosophic democratic framework within which we can formulate our arguments which will come to our rescue at the time of attack.

Basic Aspects of Democracy

I want first to state some of the basic aspects of democracy. Some people think of it only as majority rule, while others think of it simply in terms of economic freedom with emphasis on capitalistic enterprise. Still others have a vague concept of democracy as the right to criticize those in authority in order to shift the center of political gravity from right to left, or left to right. However, a more mature and accurate idea of what democracy really means will involve these three things:

- (1) A freedom to choose between alternative ways of action.
- (2) A concept of the dignity and worth of the individual human's personality.
- (3) A way of life based upon a generally

acceptable standard of procedure in relationships between people.

The last point is essentially a simplified expression of Hypocrates' statement on medical ethics. Our profession is intimately involved in all three of these points. However, in the immediate problem which faces the profession of medicine, we are concerned primarily with the first point; namely, the freedom to choose between alternative ways of action.

If all our knowledge about everything could be compressed into three separate categories, these categories would be: first, our knowledge about inorganic behavior (those things without life about which geology and inorganic chemistry teach us); second, about organic behavior (those living things below the realm of human life), and finally, what I shall call super-organic behavior, which refers only to the behavior of man—man *not* as an organic animal, but as a human being endowed with spiritual depth and a moral nature. The members of our profession are given ample training in our laboratories on the first two categories, but are sometimes woefully inadequate in the extent of their training on the last.

Predictability of Behavior

The predictability of behavior diminishes as we move upward from the inorganic realm to the realm of man, the super-organic. For example, we can predict with awesome accuracy what will happen when the trigger of a bomb loaded with fissionable hydrogen atoms is released, or when a match is applied to dry gunpowder. In the world of simple organic creatures we also can predict with remarkable accuracy; a hen nearly always cackles when she lays an egg; an oriole builds her nest with remarkable fidelity to a pattern always used by orioles, and a newly hatched chicken, without previous experience with the problems of survival, will scurry to shelter when a hawk flies over the barnyard. When we come to man, we find that his personal behavior is highly unpredictable. No two people, we are told, ever react in exactly the same way to the same set of circumstances. This is why it is necessary in political life to recognize the “conservative mind” and the “liberal mind,” Democrats and Republicans, new Dealers and anti-New Dealers with all the different shades of opinion in between these various extremes. It is the unpredictability of man's behavior which gives him the character of a moral being and endows him with a spiritual dimension. He always has to choose between alternative ways of action, what to wear, what to eat, when to fight, and when to run away from a fight. He may also be faced with a choice of whether to follow his doctor's regimen of diet or not.

It is not just life alone that man seeks but he wants the full life. The choices which God has given him the privilege of making, he makes within the framework of his spiritual dimension. Thus, his coat is not just something to hide his nakedness, but also it may be an expression of his artistic impulse. His house is not just a shelter from rain and wind, but a symbol of his taste and his social standing in the community. The degree of his own self-respect is often reflected in his home. His food, too, is subject to many variations and refinements. It may range all the way from roots and bark of trees to caviar and champagne and even to Metrecal®. The choices which man makes may be the source of his greatness or the cause of his degradation.

The main reason for the foregoing discourse on elementary psychology is to emphasize the existence of man's moral nature and his full spiritual dimension—if democracy has any spiritual basis—and we must believe that it does have—it is this: democracy gives to man the greatest freedom of choice. In contrast, we know that a communist or fascist dictatorship provides man with only limited choices. They organize and control all facets of life and culture, even to the extent of dictating what scientific theories may be taught in colleges and universities.

Man's Most Prized Possession

This freedom to choose is man's most prized possession in a democracy. It is essential to his dignity and to the full expression of his personality. This idea of human dignity is the greatest common denominator between democracy and Christianity. It is also exactly at this point that we recognize the greatest and most violent source of ideological conflict between democracy and communism.

Thus, we see that Marxist socialism is irreligious. It fails to recognize man's spiritual dimension. It attempts to dehumanize man by depriving him of the right of open and free discussion upon which he must base an intelligent decision of his own. This free and unbridled discussion gives man an open market of human ideas and experiences out of which he may choose those which to him seem creative and worthwhile. This is why we believe that in the long run of history, Marxist socialism is doomed to utter failure, for neither laws nor ideologies will change the fundamental nature of man. The doctor-patient relationship which has existed in the past must be maintained. The freedom of patients to choose their own doctor is also essential. The integrity of a doctor's choice of regimen, based on a patient's medical history and his intimate psychological experiences, also is important.

But I want to warn you against the common practice of name-calling. Every proposal for the medical

care of the aged and indigent which we do not like is not necessarily Marxist, nor even undesirably socialistic. To denounce it as such is to place our profession in a most indefensible position before the public—not much better than that of the John Birch Society.

It is inconceivable to the American public that the medical profession should oppose any kind of public medical care for the aged. What we need to do is to tell the public what kind of program the profession thinks should be inaugurated, why we think so, and why we oppose programs which we are against. The public is not convinced that we have any interest whatever in any patient who cannot afford our services. We are fast approaching that contradictory status where we are the most despicable and unpopular professional group in the country—and at the same time the most necessary and potentially the most respected. Our public image is suffering through unfavorable publicity. If we have a story to tell, why don't we go ahead and tell it from the grass roots level, the county medical societies, instead of from the level of the American Medical Association.

Our public relations department has been probably the most sadly neglected of any profession in the country. If you do not believe this, just remove the label of your profession for half an hour and walk among laymen and encourage them to talk, to tell you what they think of us. You will find that about three-fourths of the complaints will concern high fees. He has heard unfavorable publicity of such practices as fee splitting between the general practitioner and the specialist and kick-backs paid by drug manufacturers. He resents having to pay for things he does not believe he needs, some services and some medicines.

An extravagant display of wealth is a sly joke among physicians' neighbors because they feel this was made possible by their own suffering, misfortune, and personal tragedy through the operation of a professional practice which was largely non-competitive.

Face Criticisms and Develop Programs

We need to face up to some of these criticisms and develop programs to meet them if they are true and to correct those impressions that are false. The image of doctors in the public mind will not be improved unless we do something more positive in the future than we have been willing to do in the past. This society in which we are living is vitally concerned with the problems of its elderly citizens. As a most appropriate program for your county medical societies, I suggest a joint panel of doctors and laymen for the free and open discussion of some of

the problems with the public being invited to participate. To avoid such a challenge of a free discussion is to deny and to down-grade the democratic process to which we all should be committed, and to lay ourselves open to further criticism and eventual defeat of our efforts to determine the proper direction which public medicine in America should take.

In addition to the problem of public relations discussed above, I am outlining below what I consider to be the major medical problems which face the Medical Association of Georgia. These problems require urgent attention.

Chronic Diseases and Health Care of the Aging

The medical profession has given its support to the Kerr-Mills Bill and now it is our responsibility to see that it works through our full cooperation, participation, and possibly some phase of regulatory administration. It is up to us to prove that medical assistance for the aged can be based on the philosophy of "need and not right," of local control and administration, and of the free choice of a physician.

Although Forand-type legislation was staved off temporarily last year with the passage of the Kerr-Mills Medical Assistance Plan to help the aged at the state and county levels, the election of a new Democratic Congress and administration favoring the Forand approach, signals the beginning of another drive this year for the passage of a medical care program for the aged which is tied to the Social Security Program. Doctors recognize that many persons over 65 have serious problems in financing medical help for those who need help. However, physicians do not believe that a compulsory program of medical assistance is the appropriate answer, particularly since many of those over 65 neither need nor want federal assistance in financing medical care. It is, therefore, imperative that every society take immediate action to help implement the Kerr-Mills Plan and to see that it is made to operate at maximum efficiency in the State.

Since the health needs of the aged involve far more than hospital and medical care—in fact such a person's whole way of life and stature within our society may be affected—medical societies must also exert new leadership in setting up non-legislative programs for the aged which are geared to community needs. In this connection, I want to quote the "Senior Citizen's Charter," wherein the right of every senior citizen, regardless of race, color or creed is set forth in the following points: (1) the right to be useful; (2) the right to obtain employment, based on merit; (3) the right to freedom

from want in old age; (4) the right to a fair share of the community's recreational, educational, and medical resources; (5) the right to obtain decent housing suited to needs of later years; (6) the right to the moral and financial support of one's family so far as is consistent with the best interest of the family; (7) the right to live independently, as one chooses; (8) the right to live and to die with dignity, and (9) the right of access to all knowledge as available on how to improve the later years of life.

With the possession of these rights, the senior citizens will be happy and contented and such a person is well on the road to dignity and happiness in his aging years.

Mental Illness

I am sure all of us are aware of the need in the large and important field of mental illness, and of the strides which the Medical Association of Georgia has made in improving institutional care and treatment of the mentally ill. This Association should continue its leadership in this field and keep the public informed at all times of this continuous problem. We might well take the initiative for the sponsorship of a national conference during 1961 to draw many different groups into a concerted effort to solve some of the problems which confront us in this field. Following this national conference, materials and suggested projects will be offered to medical societies tackling this problem within their various communities.

Reorganization of Committees

I recommend that we reorganize our committees in the Medical Association of Georgia so as to coordinate our efforts and to increase our strength and communications.

Supply of Physicians and Proper Placement

The Medical Association of Georgia needs closer ties with the Placement Bureau in making the proper distribution of physicians and to help in directing new physicians to localities desiring their services, and to cooperate with the Board of Medical Examiners to insure proper distribution of scholarship M.D.'s.

National Debate Topic "Compulsory Health Insurance"

Placement of kits of materials available through the American Medical Association for use of students and laymen in debating this topic. These kits help them form an unbiased opinion on the question of "Compulsory Health Insurance." This is something which could well be inaugurated in the county, at the grass-roots level.

Intra-Membership Relations

The links (county medical societies) should be strengthened to form a strong M.A.G. chain. Councilors from each district and the large societies must stimulate the county societies within their district to assume medical leadership of the community. Societies should conduct a continuous educational campaign among the profession and public to improve relationships. New society members particularly should be alerted to ways to prevent breakdowns in this relationship at orientation sessions devoted to the subject, with special emphasis given to such topics as efficient business practices and advance fee discussions as means of forestalling future differences with patients. Old members also should be reminded periodically, by special articles in medical bulletins and an occasional program on the subject at the medical meetings, that the preservation of our present system of medicine depends on better public relations than we have had in the past.

Cooperation With Other Organizations

Because health care of the public is such a complex field, with other participants besides physicians, the Medical Association of Georgia should improve its liaison with other organizations, such as the Georgia Hospital Association, the Georgia

Association of Nursing Homes, the Georgia Pharmaceutical Association, Chambers of Commerce, farm groups, and other civic organizations. In this manner, the aims of the Medical Association of Georgia will be better known and understood.

Legislation—National and State

The primary purpose of the Medical Association of Georgia is to promote the science and the art of medicine and the betterment of public health. As the "Guardian of Georgia's Health," this association must maintain and improve its legislative liaison at the county, state, and national levels. It is the association's duty, as the authority in the field of health care, to provide legislators with data on good medical care when proposed health care legislation is pending. The association should take an active part in all matters which effect the health of all the citizens of Georgia.

Let me, in conclusion, remind you again that we are in a rapidly changing world—political, social, economic, and technological, and we must continue our fight to check the undemocratic and bureaucratic tendencies which accompany the inauguration of new procedures. TO THAT TASK, I DEDICATE OUR EFFORTS FOR THE COMING YEAR. WITH YOUR HELP AND GOD'S HELP, WE SHALL SUCCEED.

GOVERNOR VANDIVER BREAKS GROUND FOR NEW BUILDINGS AT MILLEDGEVILLE

GOVERNOR S. ERNEST VANDIVER broke the ground for new buildings at the Milledgeville State Hospital at ground breaking ceremonies March 29, 1961.

Construction on additional facilities for Milledgeville State Hospital and for the Georgia Training School for Mental Defectives at Gracewood is scheduled to begin this month.

Included in the Milledgeville expansion will be a 627-bed addition to the Arnall Building, a 500-bed intensive treatment and training center, a central kitchen, and a staff dormitory and staff apartment building. This is one of the largest single building projects in the institution's history, and is expected to total about \$7.1 million.

Immediate plans for Gracewood include the construction of a new 300-bed infirmary at an estimated cost of \$1.7 million.

The four-story addition to the Arnall Building at Milledgeville will provide facilities for around 600 resident patients.

The new 500-bed intensive treatment building will be used for the admission and screening of all new pa-

tients. Immediate medical treatment as well as rehabilitative services will be offered in this center. Plans also call for the use of this building for additional training for psychiatric residents, nurses, aides, and other personnel.

All food for the hospital will be prepared and delivered from the central kitchen. More economical and efficient food service operation is expected.

Housing facilities for the hospital professional staff will be expanded with the 100-bed dormitory for unmarried male and female employees, and the 24-unit apartment building for married professional employees and their families.

With the addition of the third infirmary at Gracewood, more space will be provided for those patients who require full-time care. At the present time individuals are in dormitory-type units which are unsuited for maximum care. This 300-bed addition, plus the two recently completed 50-bed dormitories for Negroes, will enable an expansion of patient population to approximately 1,900.



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OUTSTANDING FOR "SPECIAL-PURPOSE" THERAPY

ARISTOCORT Triamcinolone has long since proved its *unsurpassed efficacy and relative safety* in treating allergic respiratory disorders, including bronchial asthma. Clinical evidence has now shown that ARISTOCORT is also highly valuable for "special-problem" patients—asthmatic and others—who, because of certain complications, were hitherto considered poor candidates for corticosteroids.

for example:

PATIENTS WITH IMPENDING CARDIAC DECOMPENSATION

In contrast to most of its congeners, ARISTOCORT is not contraindicated when edema is present or when cardiac decompensation impends.¹

PATIENTS WITH EMOTIONAL AND NERVOUS DISORDERS

Triamcinolone did not produce psychic disturbances or insomnia.²

PATIENTS WHOSE APPETITES SHOULD NOT BE STIMULATED

Among patients treated with ARISTOCORT, there was less appetite stimulation, especially in those who had previously gained weight on long-term therapy with other steroids.³

PATIENTS WITH HYPERTENSION

There was no blood pressure increase in any patient treated for bronchial asthma, and in some, blood pressure fell. Of these, three had been hypertensive.⁴

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Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of allergic respiratory disorders, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white).
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LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

SUCCESSFUL TREATMENT OF RESISTANT EDEMA: THE ROLE OF ADRENOCORTICAL HORMONES

Patients resistant to conventional diuretic efforts may again respond to these agents after the addition of glucocorticoid to the treatment regimen.

Roy A. Wiggins, Jr., M.D., *Atlanta*

THE FORMATION OF EDEMA is a complex process involving local considerations such as flow in venous and lymphatic channels, distribution between intracellular and extracellular spaces, and capillary permeability; involving hemodynamic factors such as cardiac output, renal plasma flow, and glomerular filtration rate; involving water metabolism in and of itself as influenced by the antidiuretic hormone, and involving mineral metabolism as influenced by the secretion and degradation of aldosterone.

In considering the role of the adrenal cortex in edema, one remembers that the distribution of water and electrolytes between intra- and extracellular compartments is directly affected by hydrocortisone, and perhaps to a lesser degree by aldosterone. Hydrocortisone, in maintaining homeostasis, maintains cardiac output, renal plasma flow, and glomerular filtration rate. Aldosterone exerts its effect primarily at the distal convoluted tubule where this steroid influences the exchange of sodium ions for potassium and hydrogen ions. As the tubular fluid reaches the collecting ducts, hydrocortisone influences are again detectable, in that the concentrating mechanisms appear to be dependent upon adequate amounts of circulating glucocorticoid.

The clinical physiologist has little difficulty in explaining the elaboration and the mechanisms for the control of elaboration of hydrocortisone. The control of aldosterone secretion, however, is enigmatic.¹ Aldosterone secretion rises with a decreased extracellular fluid volume and falls with increasing effective extracellular volume. As we understand the situation today, aldosterone is secreted by the outer or glomerular layer of the adrenal cortex in response

to some humoral factor—not ACTH. The magnitude of aldosterone response to various physiological stimuli does seem to depend on the presence of adequate amounts of ACTH. An aldosterone stimulating factor may be elaborated by the pineal gland, as suggested by Gordon Farrell, but this is unproven.

In the mid-1950's, Luetscher and his colleagues² were able to isolate and crystallize aldosterone from urines collected from patients with congestive heart failure, the nephrotic syndrome, and ascites due to hepatic cirrhosis. Since that time many workers have shown increased concentrations of aldosterone in the urine of patients suffering from various types of edema. Recently, studies by Ulick, *et al.*,³ have shown that the secretion rate of aldosterone is markedly increased in patients with hepatic cirrhosis and ascites and patients with the nephrotic syndrome, but not in a small number of patients studied with congestive heart failure. It is apparent that aldosterone is only one aspect of the pathogenesis of edema.

While it is known that the human adrenal cortex does elaborate desoxycorticosterone (DOC), this hormone does not play a very important role in the formation of edema or in the retention of sodium in the usual clinical setting. Patients treated with certain enzyme inhibitors,⁴ and some patients with congenital adrenal hyperplasia do secrete large amounts of DOC, and their body sodium economy does depend upon this compound.⁵

In the 1930's, Loeb, Atchley, and their co-workers,⁶ showed that patients with Addison's disease lost large amounts of sodium in their urine producing a low sodium concentration in the blood. It, therefore, seemed feasible to remove the hormones of the adrenal cortex in the treatment of resistant edema. Schiff, and others,⁷ subjected cirrhotic patients to adrenalectomy with subsequent diuresis.

However, when sufficient hormone replacement was offered these patients to protect them from adrenal crisis, the ascites reaccumulated.

Pharmacological Approach

Surgical adrenalectomy failing, a pharmacological approach was appraised. Thorn's group,⁸ amongst others, administered amphenone to patients with edema. Amphenone is a drug which inhibits the elaboration of the hormones of the adrenal cortex in general, possibly by enzyme inhibition on a large scale. Patients given amphenone did experience some water and sodium diuresis; however, they became so ill that therapy had to be discontinued. Those patients with hepatic cirrhosis presented a picture resembling early hepatic coma. An analogue of D.D.T., D.D.D., has recently been studied by Dr. Harmon Brown⁹ with similar experience. It is worthy of note that all patients so treated did not actually experience loss of sodium and water. Resistance to conventional diuretic therapy was relieved by D.D.D., however.

Holub and Jailer⁴ have suggested the use of compound SU-4885, an 11 beta hydroxylase inhibitor, in treating resistant edema. This drug acts by inhibiting the formation of compounds having a hydroxyl group in the 11 position of the steroid nucleus, thereby blocking the production of aldosterone at an enzyme level. The sodium and water loss in response to administration of this compound was not particularly striking; however, administered in conjunction with 15-30 mg. of prednisone daily, gratifying natriuresis and water loss were observed. Apparently, the prednisone suppresses the elaboration of the mineralocorticoid desoxycorticosterone in patients subjected to this enzyme-blocking action.

Addition of Steroid Hormones

Another approach to the use of adrenal cortical hormone in therapy of edema, has been the addition rather than the removal of steroid hormones. In 1955, Schemm and his co-workers¹⁰ reported the use of adrenocorticotropin (ACTH) in the edema of heart disease. Of 21 cases treated, 81 per cent benefited. Four subjects experienced a spontaneous diuresis during therapy, three subjects experienced a spontaneous diuresis after cessation of treatment, and an additional ten patients experienced an altered response to other diuretic efforts. Unfortunately, eight of the patients studied were diagnosed as having rheumatic heart disease. It is unclear whether the corticotropin influenced the rheumatic heart disease, or whether the effect was on water and salt balance.

Rierner,¹¹ in 1956, studied extensively a 47-year

old male with arteriosclerotic heart disease with refractory congestive heart failure. Administration of 2.5 mg. of prednisone three times a day effected an immediate increase in urinary output. Furthermore, the patient responded with a loss of water and sodium when given mercurial diuretics, whereas just prior to the administration of the glucocorticoid, diuretic resistance had been noted. Carbone and Matthews,¹² reported the study of 12 patients with chronic liver disease and edema given prednisone in an effort to initiate or potentiate diuresis. Two of their patients experienced good diuresis while on prednisone, 20-40 mg. daily, while only a slight increase in water and sodium excretion was observed in two additional patients. Five of the remaining patients, previously resistant to conventional diuretic therapy, experienced satisfactory natriuresis with these drugs after the institution of prednisone therapy. Carbone's experience is typical of the experience of other workers in this country and abroad.

Synthetic Hydrocortisone Analogues

The newer synthetic hydrocortisone analogues frequently effect a sodium loss in a normal salt-depleted subject and in patients with a pathological sodium retention. This effect seems to correlate best with a substituent (either hydroxyl or methyl) in the 16 position of the steroid nucleus.¹³

The physiological explanation for the diuretic effect of glucocorticoids is not available. Some data suggest that the synthetic glucocorticoids are aldosterone competitors at the renal tubule. Some data, not uncontested, suggest that the glucocorticoid increases glomerular filtration rate, increasing the filtered load of sodium and water, thereby effecting a diuresis. Other data suggest that the glucocorticoids inhibit the elaboration of aldosterone. This would seem, however, to be an effect secondary to other physiological changes, and not primarily an action of the glucocorticoid on aldosterone secreting mechanisms. Finally, it is well known that shifts of water from the intracellular to the extracellular compartment are effected by hydrocortisone—like materials. Many students of this problem feel that the diuretic effect of the glucocorticoids can be explained entirely on the basis of this shift of fluid and electrolyte into the extracellular, relatively accessible, compartment of the body.

One of the more interesting aspects of hormonal therapy of edema is the competitive inhibition of aldosterone effect. One example of this may be found in the spiro lactone compounds¹⁴ recently made available by one of the larger drug houses. The feeling that spiro lactones function as competitive inhibitors of aldosterone at the tubular level is derived from the absence of effect of these compounds in adrenal-

RESISTANT EDEMA / Wiggins

ectomized subjects; the fact that diuretic response depends on the ratio of drug to mineralocorticoid; the fact that aldosterone secretion is not inhibited, but actually rises during therapy with these compounds, and that no demonstrable changes in renal circulatory dynamics have been observed during therapy with spiro lactones.

Probably the best evidence that the spiro lactones inhibit aldosterone at a cellular level was brought out in Dr. Alexander Leaf's laboratory.¹⁵ For some time Dr. Leaf and his associates have been working with the measurement of ion flux across the toad bladder using a technique developed by Ussing. Crabbé, working with Leaf, demonstrated that aldosterone stimulated the active transport of sodium ions from the serosal to the mucosal side of the toad bladder. By adding Aldactone,[®] as well as aldosterone, to his serosal bath, Crabbé was able predictably to block this aldosterone-induced transfer of sodium ions. The degree of blockade correlates with the ratio of aldosterone to Aldactone,[®] supporting the competitive inhibition hypothesis.

Aldosterone Antagonists

Aldosterone antagonists may be used in the treatment of edema characterized by excessive retention of sodium. Of course, its most gratifying performance is in those patients with refractory edema. We have had no success in the use of aldosterone antagonists in patients with edema characterized by excessive retention of water and the hyponatremic syndrome. Although many workers have experienced good results using aldosterone antagonists in edema of renal disease, this group of patients has been the least responsive in our experience. Failure must not be accepted when antagonist therapy has been used alone for less than five days.

Aldosterone antagonists may be administered intravenously, intramuscularly, or by mouth. The only commercially available preparation is designed for oral administration. This may be given in dosages of 100 mg. every six hours alone, or with another diuretic substance. Many patients will diurese with aldosterone-antagonist therapy solely. Frequently, however, the urinary sodium excretion is relatively increased, but the absolute natriuresis is inadequate to effect clinical improvement. In one case of tricuspid insufficiency treated with the aldosterone antagonist, SC-8109, there was a doubling of the urinary sodium excretion within four hours. In absolute terms, this represented an increase in urinary sodium concentration inadequate for therapeutic diuresis. When this patient was given mercur-

ial diuretics, to which he had previously been refractory, effective diuresis ensued. Gantt¹⁶ reported his experience in the treatment of 13 patients with cirrhosis and ascites. Spirolactone alone brought about a diuresis in five patients, or 38 per cent. Addition of a thiazide diuretic effected a diuresis in four of the eight resistant patients, and use of spiro lactone, thiazides, and prednisone, jointly, brought the total number of satisfactory responses to 11 of 12 patients so treated.

Aldosterone Antagonists Expensive

The aldosterone antagonists are not inexpensive. Aldactone[®] may be obtained for about 90 cents per 100 mg. tablet. A five-day course, then, costing about 20 dollars. Our experience has indicated that clinically acceptable diuresis may not be obtained uniformly with the antagonists alone. We have adopted the policy of administering Aldactone[®] in conjunction with one of the thiazide diuretics. Addition of a 500 mg. dose of chlorothiazide daily costs another 10-15 cents. A maximum diuresis could be obtained by the addition of prednisone in 30 mg. amounts daily. Total costs for administration of Aldactone,[®] 100 mg. each six hours, prednisone, 10 mg. every eight hours, and chlorothiazide, 500 mg. daily, for five days would be about 22 dollars. This is expensive when compared with the cost of injections of mercurials or with the less-than-one-dollar cost of a five-day course of chlorothiazide alone. On the other hand, when compared with the cost of one day's hospitalization or with the charge for an electrolyte package, five days of very aggressive therapy at \$22 does not seem to be excessive.

Manufacturers' Investigation

The manufacturers of the aldosterone antagonist have been investigating the possibility of administering Aldactone[®] and hydrochlorothiazide in the same tablet. We have had experience with a combination of Aldactone,[®] 75 mg., and hydrochlorothiazide 25 mg. This combination aldosterone antagonist and thiazide diuretic allows a striking sodium diuresis with essentially no loss of potassium. Although the thiazide does cause potassium loss, the aldosterone antagonist effects a retention of potassium. These effects tend to cancel each other.

Side effects of the aldosterone antagonists have been few. Given in large doses, these steroids cause somnolence, particularly when administered intravenously or intramuscularly to patients with hepatic cirrhosis. This is an irritating side effect which may be corrected by lowering the dosage of aldosterone

anatagonist used. These compounds are capable of creating a hyponatremia in cirrhotic patients. The sodium loss in the urine usually exceeds loss of water when aldosterone antagonists are employed. Hyperkalemia may occur in patients given potassium supplements during spinal actone therapy. There are several cases of hirsutism reported in patients given the aldosterone antagonist, Aldactone,[®] in therapeutic doses for periods in excess of six months. A maculopapular drug eruption has been reported.¹⁷

Summary

By way of summary it might be said that the consensus supports the manipulation of the adrenal cortex in edematous patients by the following pattern. In situations where the patient apparently has retained water in excess of sodium and the serum sodium concentration is low, glucocorticoid therapy may induce a water diuresis. One may use 15-30 mg. of prednisone, 12-24 mg. of methyl-prednisolone or triamcinolone, or three mg. of dexamethasone. In a small group of patients, glucocorticoid in the above dosages will induce a sodium loss, particularly the last mentioned compounds.

Patients resistant to conventional diuretic efforts may again respond to these agents after the addition of glucocorticoid to the treatment regimen.

The aldosterone antagonists are useful in problem cases, Aldactone[®] in dosages of 100 mg. daily, alone or with chlorothiazide, 250-500 mg. daily, or both with glucocorticoid administration, will very frequently produce diuresis. On occasion the aldosterone antagonist must be administered in increasing dosages because of rising aldosterone secretion.

35 Fourth Street, N.E.

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COMMUNIST BLUEPRINT

"WAR TO THE HILT between Communism and Capitalism is inevitable. Today, of course, we are not strong enough to attack. Our time will come in 20 to 30 years. To win we shall need the element of surprise. The bourgeois will have to be put to sleep, so we shall begin by launching the most spectacular peace movement on record. There will be electrifying overtures and unheard of concessions. The Capitalist countries, stupid and decadent, will rejoice to cooperate in their own destruction. They will leap at another chance to be friends. As soon as their guard is down, we shall smash them with our clinched fist."

Dimitry A. Manuilsky

Speech—1930

LIPOSARCOMA

Peter C. Sotus, M.D.; John E. Skandalakis, M.D.;
Duncan Shepard, M.D., and Rosina Vincenzi, M.D., *Atlanta*

These tumors may be easily confused clinically with benign lipomas.

LIPOSARCOMAS ARE COMPARATIVELY rare, soft-tissue lipoblastic tumors whose structure may range from the well differentiated to the almost anaplastic type.⁷ Since these tumors may be easily confused clinically with benign lipomas, we are reporting a fairly typical case seen recently at Piedmont Hospital, in an attempt to emphasize the importance of including liposarcoma in the differential diagnosis of subcutaneous or soft-tissue masses.

Case Report

Mr. W. E. L., a 56-year old white male, was admitted to the hospital on October 13, 1959, with a history of a gradually enlarging mass of the right thigh, first noted about five or six months previously when it was the size of a pea. There was no pain associated with the mass, but it had gradually become tender. His history was otherwise not remarkable, except for the removal of a "fatty tumor" from his back 25 years previously.

Positive physical findings were limited to the upper lateral right thigh. A six centimeter, tense, freely movable, multilocular, cystic-feeling mass was present in this area; it was moderately tender. In addition, he had a soft two centimeter, hemispherical, subcutaneous mass just medial to the middle third of the right sternomastoid muscle, which was thought to be a lipoma.

On October 14, 1959, he was taken to the operating room where the mass in the thigh was removed under general anesthesia. A frozen section was ob-

tained which showed "sarcoma, type undermined." A wide excision of the apparently encapsulated, necrotic mass was performed. There was no evidence of attachment or invasion of the deep fascia.

The pathology report was as follows: "The permanent sections confirm the frozen section diagnosis of sarcoma. The tumor varies considerably in appearance from place to place. In some areas spindle cells which show only moderate variation in nuclear size and staining are widely separated by a myxomatous stroma. In other places elongated spindle cells are closely crowded together, and there is striking nuclear pleomorphism. Bizarre, giant hyperchromic nuclei are rather numerous. In some areas frequent mitoses are seen. Focally, tumor exhibits necrosis. The morphologic appearance is that of a liposarcoma." (Figure 1)

The patient had an uneventful postoperative course and was discharged on October 19, 1959.

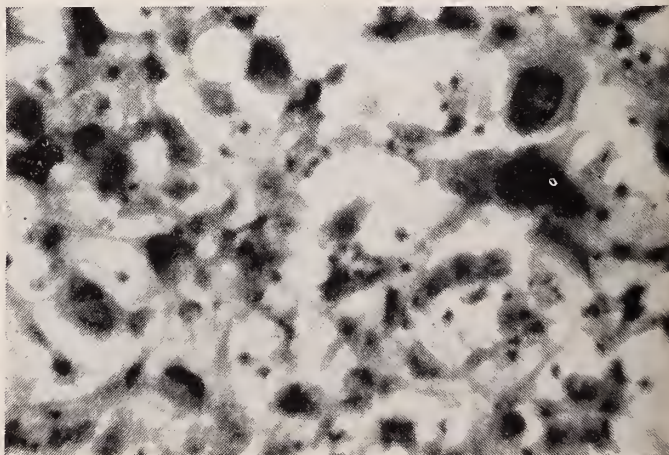


Figure 1: Primary liposarcoma showing presence of bizarre giant cells.

From the Department of Surgery and Pathology of the Piedmont Hospital, Inc., Atlanta, Georgia.

X-ray therapy was begun on an out-patient basis on November 9, 1959.

On January 15, 1960, the mass in the neck was excised and found to be a lipoma.

In March, 1960, the patient noticed a "walnut-sized" growth near the site of the previous tumor of the right thigh. He was readmitted on May 5, 1960, at which time a three centimeter, hemispherical mass was present three centimeters below the scar of the previous surgery. Physical examination was otherwise normal. A wide excision of the tumor and scar was performed on May 6, 1960.

The pathology report on the second admission read as follows: "In the sections there is a malignant neoplasm in which many large tumor cells are present. Some of the tumor is myxomatous in appearance. There is considerable edema. The tumor cells vary in size. Cytoplasmic outlines are indistinct. Some of the nuclei are large and ovoid. Mitoses are present. There is very heavy infiltration of inflammatory cells throughout. The margins of this lesion are clear of tumor, and it would seem that the neoplasm has been completely excised. Diagnosis: Liposarcoma." (Figure 2)

The patient was discharged on May 9, 1960, after an uneventful hospital stay.

X-ray therapy was begun as an out-patient on June 30, 1960.

On June 21, 1960, a soft, five centimeter, hemispherical mass was discovered in the subcutaneous area over the left scapula. This was thought to be a lipoma. It was excised under local anesthesia, and the diagnosis of lipoma was confirmed.

Comment

Liposarcomas are slightly more common in males than in females. This is in contrast to the greater frequency of benign lipomas in females.⁵ Although they are more common in the middle age group, several have been reported in children.³ Almost two-thirds of these tumors are found in the thigh, buttocks, groin, legs, and feet, and approximately one-fourth

are in the upper extremities. The remainder are on the trunk and in the retroperitoneal space.⁵ Liposarcoma is the most common of the sarcomas in the retroperitoneal area.⁴ Rarely, liposarcomas are seen to develop in pre-existing lipomas or secondary to trauma,⁵ but these are by far the exception rather than the rule.

In the extremities, liposarcomas are usually associated with the intermuscular, deep fascia, and periarticular tissues, in contrast with the benign lipomas which are most common in the subcutaneous tissues. They have an insidious onset, usually painless, with the patient noticing a gradually enlarging tumor or swelling of the soft tissues. They may have a rubbery consistency, may be nodular, and may be fixed to the underlying tissues. The primary lesion does not invade these tissues, but the recurring liposarcomas tend to be invasive and to be more anaplastic.^{2,5} The primary tumor seems to be encapsulated; therefore, the surgeon may feel he is dealing with a benign tumor and simply enucleate the lesion.⁵

Stout's Classification

Stout⁶ considered liposarcomas as all belonging to a single group, capable of various degrees of differentiation and thus proposed the following classification:

1. *Well Differentiated Myxoid Type*: this type resembles embryonal fat and consists of adult fat cells, embryonal stellate, or spindle-shaped fat cells containing droplets of lipid. A rich capillary network is usually present. Mitoses are rare.
2. *Poorly Differentiated Myxoid Type*: this differs from Type No. 1 in that the lipoblasts are bizarre, often monstrous, with frequent giant, misshapen hyperchromic nuclei. Signet-ring forms may be seen, as well as areas of spindle cell sarcoma. The capillary network is variable and insignificant when compared with Type No. 1. Although mitotic figures are rare, this is definitely a malignant type.
3. *Round Cell or Adenoid Type*: the lipoblast here is rounded and contains a centrally located nucleus and lipid filled vacuoles. There is no prominent capillary network, and the tumor is not myxoid. Giant multinucleated cells containing a few large fat droplets may be seen. There may be occasional mitotic figures.
4. *Mixed Group*: two or more of the above elements are present in this group.

It has been shown that the larger and more slowly growing of these tumors tend to be of the

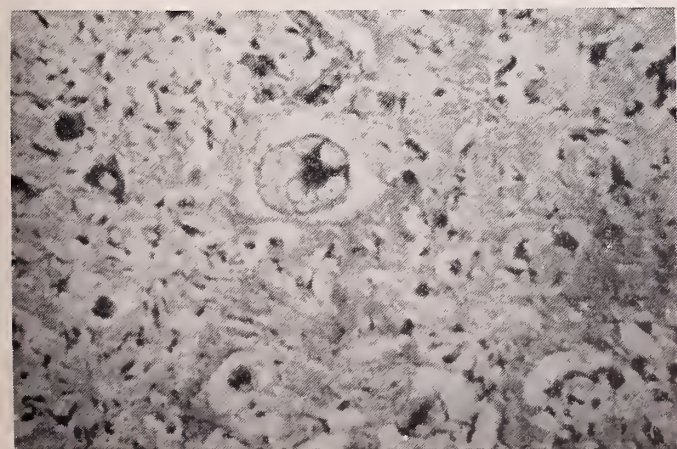


Figure 2: Recurrent liposarcoma with spindle shaped lipoblasts and bizarre giant cells with foamy cytoplasm in mucoid stroma.

LIPOSARCOMA / Sotus

well differentiated myxoid types, while the more rapidly malignant are of the adenoid and mixed types.¹ In children the well differentiated liposarcoma, which is locally invasive, tends to recur, and rarely metastasizes, is the most common.³

Treatment is primarily surgical. One should be suspicious of a subcutaneous tumor which suddenly shows progressive growth, especially if it has the characteristics mentioned above. A frozen or paraffin section should be obtained. One need not perform so radical a procedure for Type No. 1 as for the other three, but even in this, the surgeon must be careful to remove the entire capsule and surrounding tissue; for although the most he may expect from a Type No. 1 is a local recurrence, the recurrent tumors are not encapsulated and tend to be more anaplastic. A recurrent tumor should be excised widely, including the entire scarred tract down to the tumor. If the tumor is on an extremity, the dissection should begin proximal to the tumor and should be carried distally.⁵

Of the common soft-tissue sarcomas, the liposarcomas are the only ones which show some response to radiotherapy.⁴ The embryonal myxoliposarcomas are especially radiosensitive. Pack and Pierson believe this may be partly due to the fine capillary network in the stroma, which is easily damaged by irradiation. If x-ray is used preoperatively, one should wait five or six weeks for maximal regression of the tumor before undertaking surgery. If the tumor overlies or invades bone, x-ray should not be used. Although recurrent liposarcomas tend to be less sensitive to irradiation, metastases may respond quite well. The study of Pack and Pierson shows an overall cure rate of 35.9 per cent, with the best results (87.5 per cent five-year cure) in

those which were amenable to local excision and postoperative x-ray therapy.⁵

Although Type No. 1 liposarcomas have a good prognosis when properly treated, the prognosis of the other three should be guarded.¹ If the tumor, whether primary or recurrent, reveals areas of spindle cells resembling fibrosarcoma and rather extensive areas of necrosis, the patient will probably be dead in a matter of months. Those with a large number of lymphocytes and/or plasma cells tend to have a more prolonged course.

Summary

1. A case of liposarcoma of the right thigh is reported.
2. The clinical picture, pathological classification, and treatment are discussed.

Addendum

Since submitting this paper for publication, Mr. W.E.L. was readmitted to the hospital twice. An abscess in the right groin was incised and drained on December 17, 1960. Since the material obtained liposarcoma he was readmitted in January for a right groin, iliac, and preaortic node dissection on January 10, 1961. No tumor was found in these nodes and when last seen on April 21, 1961, there was no evidence of recurrence or metastasis.

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AMGA TOURNAMENT TO BE HELD AT WINGED FOOT GOLF CLUB

THE 45TH ANNUAL TOURNAMENT of the American Medical Golf Association will be held at the Winged Foot Golf Club, Mamaroneck, N. Y., Monday, June 26, in conjunction with the annual meeting of the American Medical Association in New York City, June 25-30.

The club has two championship 18-hole golf courses and was the site of the 1958 U. S. Open Golf Tournament.

The annual banquet and presentation of the day's trophies will be held in the club house the same evening.

All members of the A.M.A. are eligible to participate. Golf clubs may be rented at the club house. Additional information on the tournament may be obtained from Dr. William G. McVay, Postoffice Box 7007, Kansas City 13, Mo.

JAUNDICE IN ACUTE CHOLECYSTITIS

An analysis is made of 13 jaundiced patients who had cholecystectomies for acute cholecystitis, whose common ducts were found to be free of obstruction by stones, and whose jaundice disappeared in a few days after operation.

J. H. Hilsman, M.D., *Atlanta*

IT HAS BEEN REPORTED that anywhere from 17 per cent to 30 per cent^{1,2} of the cases of acute cholecystitis are accompanied by jaundice of which only about 10 per cent are due to common duct stones. Freund¹ reported 140 cases of acute cholecystitis, 42 of which were clinically jaundiced; in only four of these cases were common duct stones found. Barrow and Massie³ reported a 26.6 per cent incidence of jaundice in acute cholecystitis in which only 7.7 per cent of the cases were common duct stones found. So, it is felt that common duct stones are not the only cause of jaundice in acute cholecystitis, in fact, they represent a relatively infrequent cause.

Hepatitis as the cause of this type of jaundice was offered in 1918 by Graham,⁴ who reported an 87 per cent incidence of hepatitis in acute cholecystitis from a study of surgical biopsies taken at the time of cholecystectomy. Since that time Colp⁵ has reported aspiration biopsy studies of the liver at sites far removed from the inflamed gall bladder as showing only mild parenchymal cell degeneration. It was felt these changes were more likely due to bile stasis or obstruction rather than to hepatitis. Freund¹ has reported three and four plus positive cephalin cholesterol flocculation tests in 31 per cent of his jaundiced patients with acute cholecystitis as opposed to similar positive findings in only three per cent of his non-jaundiced patients with acute cholecystitis. Other reports⁶ have indicated a positive reaction to the colloidal gold test in a much higher percentage of patients with acute disease of the gall bladder. Therefore, it is felt by most authors on this subject that the changes that do occur in the livers

of these jaundiced patients with acute cholecystitis are more likely the result of the jaundice or the acute gall bladder disease than the cause of either.

Hypertrophy of the portal lymph nodes either by leukemic or inflammatory enlargement, *per se*, is not a cause of jaundice,⁷ as enlarging nodes in the porta hepatis have room for expansion and do not obstruct the extrahepatic ducts, unless there is fixation of these ducts by carcinomatous infiltration of the nodes within the walls of the ducts or the pancreas.⁸

Choledochoduodenal Sphincter Mechanism

It is fairly well accepted that the choledochoduodenal sphincter mechanism has sufficient contractile force to prevent the flow of bile into the gut.⁹ This has been visualized by direct x-ray visualization⁹ and by peritoneoscopic cholangiographic study.¹⁰ Such reflex contractions of this sphincter in man secondary to disturbances in more remote organs have not been demonstrated,¹¹ but rather the contractions are felt to be secondary to local common duct inflammatory changes,¹⁷ such as stones in the distal common duct, pancreatitis, or regurgitation in the common duct of intestinal contents. Nevertheless, the evidence that jaundice may be due to spasm of the sphincter of Oddi is still not convincing.⁷

Other authors^{9,6,12,13,14} indicate that most probably the jaundice in those cases of acute cholecystitis without common duct stones is due to inflammatory edema of the common duct at its junction with the cystic duct. Andrews¹³ has well shown that in acute cholecystitis, bacteria play a very in-

significant role and that chemical injury is more often responsible for the inflammatory changes of the edema in the gall bladder wall, the cystic duct wall, and in the wall of the common duct. He has reported the presence of marked edema in the walls of the gall bladders and cystic ducts of four jaundiced patients with acute cholecystitis with massive inflammatory edema about the junction of the cystic and common ducts. He felt that "most cases of partial jaundice are to be explained on this basis." The jaundice of children with acute cholecystitis is also thought due in some way to an acute inflammatory process adjacent to or involving the ducts rather than to common duct stones.¹⁴

Purpose of This Paper

The purpose of this paper is to report a study of the jaundice that accompanies acute cholecystitis when that jaundice is not associated with the presence of common duct stones. This study is based upon a review of the charts of 13 jaundiced patients who had had cholecystectomies for acute cholecystitis, whose common ducts were found to be free of obstruction by stones, and whose jaundice disappeared in a few days after operation.

Unselected cases of acute cholecystitis with jaun-

dice at the time of their entry into the hospital were reviewed for those charts sufficiently complete to confirm the presence of jaundice, to indicate something about the type of jaundice (urinalysis, liver function tests, liver biopsies, stool reports, etc.), to prove the absence of common duct stones at the time of cholecystectomy by common duct exploration and/or cholangiograms, and to indicate a clearing of the jaundice prior to departure from the hospital. Thirteen such cases are reviewed.

Table 1

In Table 1 it appears that all patients were either clinically or chemically jaundiced or both. In eight out of the 13 cases a note was made in the chart as to the paleness of the stools. Although none of the patients had studies for an increased hemolysis, the jaundice was not acholuric in 11 out of the 13 as indicated by the presence of bile in the urines of these 11 patients. Nine patients had parenchymal cell liver function studies done and in all they were within normal limits. In the two cases in whom alkaline phosphatase tests were done, the values were only very slightly elevated. In ten out of the 13 cases the common ducts were explored, and in seven of those explored normal cholangiograms were subsequently recorded. In only two cases were the common ducts definitely dilated, and in one of these the

JAUNDICED PATIENTS WITH ACUTE CHOLECYSTITIS														
Data collected at time of jaundice - all explored - none had C.D. stones														
Table No. 1 Case No.	Clinical jaundice	Stool color	Bile in urine	Urine urobilinogen Ehrlich unite	Blood amylase Mgm%	LIVER FUNCTION TESTS					Common duct explored	Cholangiogram	Liver biopsy	Common duct dilated
						Serum bilirubin Mgm%	C.S.Flocc 48 hrs	Thymol turbidity	B.S.P. (45min)	Alkaline phosphatase				
No. 1	Icteric sclerae					3.6	1 plus	1.1		48%	Yes	No	No	No
No. 2	Obvious jaundice	Putty	Positive	1.6	109	17.6	3, plus	4.3			16.8 K&A unite	Yes	No	No
No. 3	Icteric sclerae	Putty	Very dark urine			3.4	2 plus	1				Yes	No	No
No. 4	Obvious jaundice	Brown	Trace			5.4						No No stone felt	No	Liver normal Pancreas Normal
No. 5	Icteric Sclerae	Pale	Bile stained	Not increased	568	4.9	0	3				Yes	Yes normal	Liver normal Thick head of pancreas
No. 6	?Icteric sclerae		Dark		588							No	No	Normal liver cells. No stasis or necrosis
No. 7	Obvious jaundice	Clay colored	Dark									Yes	Yes normal	Liver normal
No. 8	No				60	2.1	1 plus	1		4%		Yes	Yes normal	No
No. 9	Obvious jaundice	Clay colored	Positive	Strong plus		4.5	2 plus	4				Yes	Yes normal	Fibrosis pancreas head on biopsy
No. 10	Moderately icteric	Yellow	Dark	0.4		2.1						Yes	Yes Normal	No
No. 11	Sclerae slightly icteric		Dark			1.5	0	3				No	No	Liver appeared normal
No. 12	Obvious jaundice	"white" stools	Dark amber		468 334	1.7	1 plus	0				Yes	Yes normal	Liver appeared normal
No. 13	Icteric sclerae	Light stools	Dark yellow			1.6	1 plus	1.5			4.9 Bodansky unite	Yes	Yes normal	No

serum amylase was 568 mgs. per cent and the head of the pancreas at the exploration was thought to be thickened. In six cases the liver was reported in the operative notes as being "normal."

Jaundice Characteristics

The jaundice then that accompanies these cases of acute cholecystitis seems to have certain characteristics. In the first place, it appears to be mild and transient^{12,15} and to disappear spontaneously after cholecystectomy. It has also been reported to clear even after cholecystotomy.² An operation obstruction and dilatation of the common duct are rarely found. Bile tends to be present in the urine and the stools tend to be paler than normal. Parenchymal cell studies are usually within normal limits. The previous administration of opiates and/or Thorazine,[®] the severity of the clinical symptoms, and the frequency of previous attacks do not seem correlated with the appearance of jaundice.

Temporary Type of Jaundice

Consequently the transient and mild nature of the jaundice, the light stools and dark urine, the normal parenchymal cell function studies, and the normal appearing livers all point to a temporary type of obstructive jaundice. The presence of an elevated serum amylase in four cases does not necessarily indicate pancreatitis with or without obstruction as Hall¹⁶ has reported serum amylase elevations in acute cholecystitis. Although not studied, the presence of fever has been postulated by Andrews¹³ to indicate common duct obstruction. Lester² also has indicated the application of Courvoisier's Law when a palpable gall bladder was present in 50 per cent of his jaundiced patients. However, neither fever nor palpable gall bladders were a feature of these 13 cases in this study. In only one case (case No. 5) was the head of the pancreas thickened and the common duct dilated to suggest an obstruction of the common duct by the head of the pancreas. The opiates used did not correlate with the jaundice. The possibility that small stones remaining in the distal common duct long enough to produce jaundice of a transient, obstructive nature, yet not long enough to dilate the common duct and then still being overlooked at operation, seems remote.

The few normal liver biopsies and the absence of correlation of the rare use of Thorazine,[®] plus the normal livers as to size and appearance at operation, would seem to rule out a cholangiolitic type of jaundice due to any cause.

No studies for hemolysis were done, but the urine in 10 out of the 13 cases was thought to contain

bile and the urobilinogen was not markedly increased in the four cases so recorded.

Therefore, it is felt that this obstructive type of jaundice most likely resulted from a temporary obstruction in the course of the common duct itself. The most reasonable cause for such an obstruction, based on the criteria as presented by these 13 cases in the light of the current theories for jaundice in acute cholecystitis, seems to be obstructive edema of the common duct at its junction with the cystic duct due to inflammation of that area by the acute cholecystitis.

Summary

1. The jaundice that accompanies acute cholecystitis is infrequently due to common duct stones.
2. This jaundice in which common duct stones are not present is usually obstructive in type, transient and mild in nature, and not hemolytic or hepatogenous in origin.
3. The cause of such jaundice is generally felt in the majority of cases to be due to temporary obstruction of the common duct at its junction with the cystic duct by the inflammatory changes of the area by the acute cholecystitis.

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MECKEL'S DIVERTICULUM

This anomaly is seen about twice as frequently in individuals with other congenital defects.

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MECKEL'S DIVERTICULUM, AN interesting congenital anomaly of the gastrointestinal tract, is frequently confusing because of its ability to mimic the commonly occurring acute appendicitis and mesenteric lymphadenitis, and, frequently, the gastrointestinal bleeding of duodenal ulcer and polyps of the bowel. Its incidental discovery has increased with the general broadening of indications for both emergency and elective laparotomy. The above facts, together with the recent opportunity to manage an unusual case of Meckel's diverticulitis, prompt the following report.

Case History

T. W., a three-year old white male, was admitted to the Burke County Hospital on July 20, 1960, because of a six-day history of diarrhea, cramping abdominal pain, and anorexia. Initially there was no fever, but for the three days prior to admission there had been intermittent daily temperatures as high as 102.0° F. rectally. Abdominal pain was apparently generalized for the first three days, was localized near the umbilicus for two days thereafter, and for the 24 hours preceding admission, the patient had complained of his right lower quadrant only. For the preceding 48 hours the patient refused solid food; was able to tolerate small amounts of oral liquids, but had vomited three to four times daily. The vomitus was never blood stained; was routinely bile stained, and contained previously recently ingested liquids. The diarrhea was never bloody, and for the two days prior to admission had improved on medication given by a local physician. Progressive enlargement of his abdomen had been noted by the mother for about 48 hours.

There had been no previous similar episodes, although the mother stated that the child had complained of some intermittent abdominal pain for "as long as he had been able to talk." There was no history of truma, or ingestion of any poison, such as an insecticide, and no previous diagnosis of, or therapy for, helmenthitis.

Physical Examination

Physical examination revealed a well developed, well nourished, white, male child, obviously acutely ill, and somewhat dehydrated. Respiration 28, pulse 120, blood pressure 110/60, temperature 102.0° F. Significant physical findings were confined to the abdomen, which was markedly distended and somewhat tympanitic. Definite direct tenderness in the right lower quadrant over an area 5.0 to 6.0 cm. in diameter was present with rebound tenderness present in both lower quadrants. Peristalsis was decreased in volume, infrequently heard, and it was somewhat high-pitched and tinkling in character. Rectal examination was not remarkable.

Admission hemoglobin was 11.5 gms., hematocrit 34 per cent, WBC 9,000 per cu. mm., with a differential of 62 segmented neutrophils, 12 juvenile forms, and 26 lymphocytes. Urinalysis was completely normal.

Posterior-anterior film of the chest showed a small amount of infiltration in the right hilar region, with a normal cardiac shadow. Flat film of the abdomen revealed gaseous distention of both the large and the small bowel.

With a preoperative diagnosis of acute appendicitis with perforation, exploratory laparotomy was

carried out on the day of admission under general endotracheal anesthesia through a right lower trans-rectus incision.

Upon entering the peritoneal cavity, 250 to 300 cc. of seropurulent fluid was encountered, and immediately removed by suction. Edematous, moderately distended, otherwise normal loops of small bowel were present, and trochar decompression of these loops was carried out aseptically before further exploration was undertaken.

In the right lower quadrant there was a 7.0 cm. in diameter inflammatory mass, covered by fibrino-purulent exudate; this proved to be conglutinated cecum, proximal ascending colon, and terminal ileum. The terminal ileum was hemorrhagic, thickened, and edematous; the proximal ascending colon was similarly involved to a lesser degree. Sixteen centimeters from the ileocecal valve, arising from the lateral aspect of the bowel, a "hammer-shaped" Meckel's diverticulum was present. It arose nearer the anti-mesenteric than the mesenteric border. The "handle" portion was approximately 2.0 cm. in diameter and 2.0 cm. long, and the "hammer" portion of the diverticulum was 4.0 cm. in length and about 2.0 cm. in diameter. Gross perforation was present at each end of the "hammer" portion, and a greenish-brown round worm protruded from the larger area of perforation for a distance of 2.0 cm. The bowel was thin-walled and necrotic throughout the majority of the "hammer" portion (Figure 1.) The appendix presented no change other than that secondary to the contiguous inflammatory process.

Using a McCleary-Williams aseptic anastomosis clamp, the base of the diverticulum was transected, and an oblique transverse bowel closure of the ileum was carried out with a single layer of multiple interrupted four "O" black silk Lembert sutures (Figure 2).

The incision was closed with interrupted wire sutures incorporating as a single layer the peritoneum, posterior rectus sheath, rectus muscle, and anterior rectus sheath, plus loose approximation of the subcutaneous tissues with interrupted sutures of fine plain catgut, and skin closure with interrupted fine cotton sutures.

Postoperatively, the patient was treated with naso-

gastric suction and intravenous fluids via a brachial cut-down until the passage of flatus. His hospital course was not remarkable, and condition was satisfactory for dismissal on the seventh postoperative day. Following discharge from the hospital, he rapidly progressed to complete recovery without complication.

The pathology report was ascaris lumbricoides infestation of a Meckel's diverticulum with secondary pressure necrosis and perforation. Microscopically, no evidence of ectopic gastric or pancreatic tissue was present. Numerous eosinophils were present in the wall of the diverticulum in areas where the necrosis allowed cell identification. Interestingly, no eosinophils were noted in examinations of the peripheral blood.

Discussion

Meckel's diverticulum, originally described in 1815, is a true diverticulum of the distal small bowel which should satisfy the following criteria:

- 1. The diverticulum should contain all of the usual layers of the small intestine.
- 2. It should have a separate blood supply with a mesentery.
- 3. It should appear on the anti-mesenteric border of the ileum.

However, the blood supply may be derived from the adjacent ileum or the ileal mesentery, and, upon occasion, may arise from an area quite close to the mesenteric border, or actually lie within the leaves of the mesentery, presumably due to rotation or shrinkage of its own mesentery, or adherence to ileal mesentery with later coverage by adhesions, so that it may appear to have arisen in an intramesenteric position.

Embryologically, this congenital anomaly is the

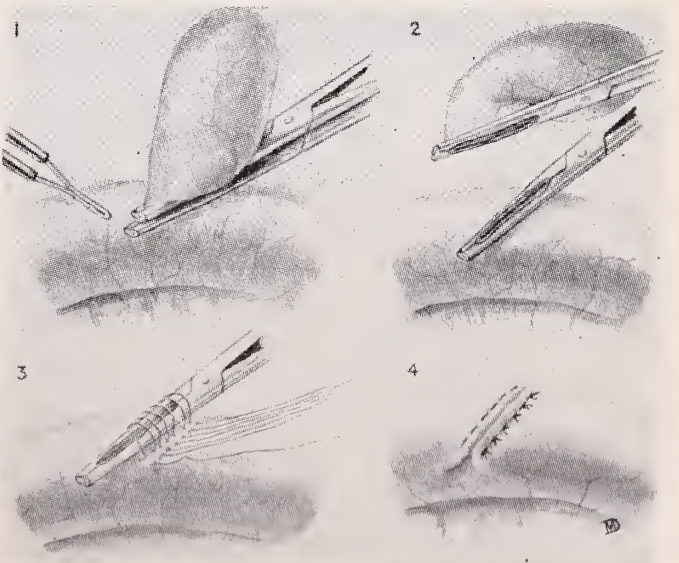


Figure 2: Recommended method of removal of a Meckel's diverticulum: (1) cautery cutting away diverticulum between Kocher clamps; (2) diverticulum has been cut away; position of the remaining clamp is shown; (3) placement of silk Halsted sutures, and (4) clamp removed; sutures snugged up. (Gross, Robert E.: The Surgery of Infancy and Childhood; reprinted by permission.)



Figure 1: Fresh specimen (a); unopened formalin fixed specimen (b), and opened fixed specimen (c).

MECKEL'S DIVERTICULUM / Byne

result of complete obliteration of the omphalomesenteric (vitelline) duct, which connects the yolk sac with the intestine. Obliteration normally begins about the fifth fetal week and is complete by the sixth fetal week.

The most common anomaly is the typical Meckel's diverticulum with a completely free tip (Figure 3h), resulting from incomplete vitelline duct obliteration near the intestine; this is the abnormality present in about 82 per cent of vitelline duct anomalies. In about ten per cent of cases of incomplete obliteration, there is a fibrous band from the tip of the diverticulum to the umbilicus (Figure 3c). Complete patency of the omphalomesenteric duct results in an umbilical fistula (Figure 3a), actually a fecal fistula, in about six per cent of the cases. Less common are the umbilical cyst (Figure 3d) and enterocystoma (Figure 3b).

The umbilical group of abnormalities has been referred to as the "sign on the door" group. Any umbilical sinus from which there is a repeated discharge of mucus or other fluids should arouse suspicion that an underlying communicating Meckel's diverticulum exists. The fluid may contain hydrochloric acid or pepsin due to heterotopic gastric mucosa present in the diverticulum. If the discharge from the fistula should be fecal, without a history of prev-

ious surgery or trauma, the diagnosis is easily made. If the discharge should not be fecal, or if any doubt should exist, a catheter may be inserted into the sinus opening and lipiodol injection followed by appropriate films would serve to confirm the diagnosis and exclude a patent urachus.

This interesting anomaly is said to be the most common anomaly of the entire intestinal tract. In a large autopsy series, its overall incidence has been reported from one and one-half to three per cent. It is found in males two to three times as frequently as in females, for no apparent reason. Symptomatically, complications of Meckel's diverticulum are present in the younger age groups. Forty-five per cent of all cases with symptoms are seen in the first two years of life, and over 90 per cent of the cases with symptoms are under 30 years of age. Meckel's diverticulum is about twice as common in children with other congenital defects, such as club-foot, spina bifida, congenital heart disease, fibrocystic disease of the lungs and pancreas—as in otherwise normal children.

Classification of Disorders

A classification of disorders of Meckel's diverticula, modified from Greenblatt, include: (1) incidental group; (2) peptic group, with ulceration, and hemorrhage and/or perforation; (3) obstructive group; (4) inflammatory group (diverticulitis, possible perforation; (5) tumors, including adenoma, lipoma, neuroma, carcinoid and even carcinoma and sarcoma. All of these are rare.

The incidental group rarely is diagnosed except at laparotomy since pain patterns are quite vague in the absence of specific inflammation, obstruction, hemorrhage or perforation. Occasionally children are seen with a history of recurrent episodes of vague, nagging, periumbilical pain, with mild nausea and vomiting and a normal physical examination. At surgery, a diverticulum, pathologically not remarkable, may be removed, and subsequently these attacks never recur.

Roentgenograms Are Characteristic

Roentgenograms are characteristic when the diverticulum can be made to fill with barium. It is seen as a persistent segment of barium which lies at an angle to the remainder of the ileum and does not show a typical small bowel pattern. However, x-ray diagnosis are quite rare, because the relatively large mouth of the diverticulum results in quick emptying, and, at best, films at intervals of five to ten minutes over a long period would be necessary for accurate contrast visualization and diagnosis. The mouth of

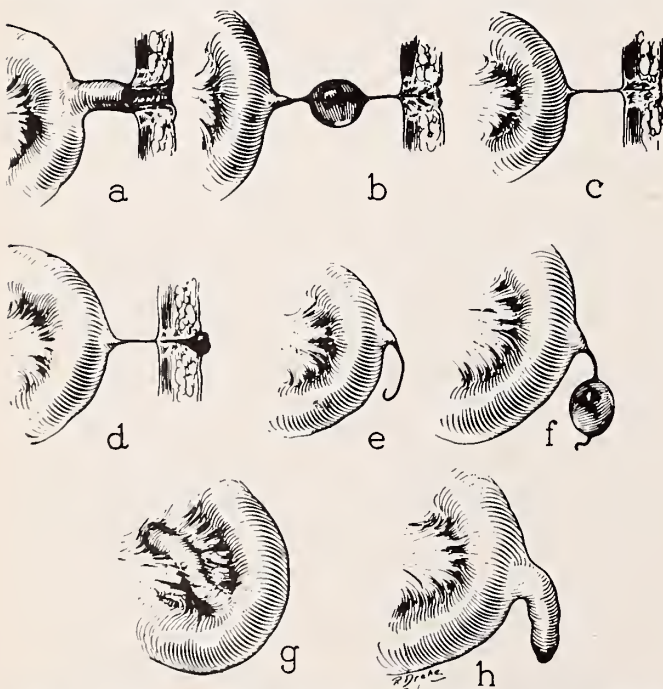


Figure 3: (a) Persistent omphalomesenteric duct with umbilical fistula. (b) Incomplete closure of duct with mid-portion presenting a cyst. (c) Closure of duct with persistent fibrous remnant. (d) Closure of duct with umbilical cyst persisting. (e) Same as (c) without attachment to umbilical region. (f) Same as (b) without attachment to umbilical region. (g) Atypical Meckel's diverticulum almost covered by mesentery. (h) Typical appearance of Meckel's diverticulum. (Dixon, C. F. and Steward, J. A.: Diverticulum with Hemorrhage: Ophaloadenoma, S. Clin. N.A., Vol. 12; reprinted by permission.)

the diverticulum is usually almost as large as the lumen of the ileum, and although this precludes accurate contrast barium meal identification, the excellent emptying is thought to be responsible for the relatively infrequent acute inflammation, as compared to acute appendicitis. It is thought that the large opening may predispose to the occurrence of intussusception.

Most Common Complication

The most common complication of a Meckel's diverticulum is hemorrhage. This occurs most commonly in children. Fifty per cent of the symptomatic Meckel's diverticula removed at the Boston Children's Hospital were due to hemorrhage.

Bleeding is the only complication of a Meckel's diverticulum where there is a relatively good chance of a correct preoperative diagnosis. This is primarily based upon the fact that the lower GI hemorrhage is usually *massive*, compared to the "spotting" of anal fissures and colon polyps, and is usually *painless*, compared to intussusception. Further, the blood is not mixed with mucus, as a rule. Typically, the first hemorrhage is severe enough to prompt the seeking of medical aid, although occasionally a history of one or more previous smaller episodes of rectal bleeding can be elicited. Almost invariably, hemorrhage is associated with the presence of heterotopic gastric mucosa within the diverticulum, and with a peptic ulcer adjacent to this tissue.

Heterotopic tissue may be gastric, duodenal, or jejunal; even colonic and pancreatic tissues have been discovered. Gastric tissue is far more common and far more clinically significant. In asymptomatic incidental cases of Meckel's diverticulum discovered at operation or autopsy, gastric mucosa was present in about 20 to 25 per cent of the cases. In symptomatic cases, gastric mucosa was present in about 60 per cent of the cases.

Several Theories of Origin

Several theories of the origin of the heterotopia have been propounded. The multipotential theory of Albrecht is based on the belief that the entoderm of the primitive digestive tract (including vitelline duct) possesses the potentiality of developing into any type of gastrointestinal tissue at any point. The implantation theory of Shactz is based upon the occurrence, during embryonic rotation, of implantation of primitive specialized entodermal cells at narrowed areas, such as the esophagus, the pylorus, the duodenum, and the omphalomesenteric duct. The dysembryoma theory of Farr and Greenblatt states

that the primitive digestive tract was the vitello-intestinal tract, and that it was a completely specialized one; when its function was over, and the duct began to obliterate, vestiges of specialized tissue remained in those incompletely regressing.

Whatever be the origin of the gastric mucosa in the diverticulum, it secretes hydrochloric acid and pepsin and does so in response to the same humoral agents as normally located gastric mucosa. With each meal there is stimulation of and secretion by the ectopic mucosa. Gastric mucosa is highly resistant to acid-pepsin digestion, but ileal mucosa is poorly resistant. Therefore, the environment is ideal for peptic ulcer formation, and it is important to note that the ulcer occurs not in the gastric mucosa itself, but in the ileal mucosa, usually immediately adjacent to the gastric tissue. This is more often at the base of the diverticulum, and a "kissing" ulcer on the opposite wall of the ileum may occur.

Second Most Common Complication

The second most common complication of Meckel's diverticulum is that of perforation. It again is more common in children than adults, and is more lethal in children than adults due to the poor "walling-off" process offered by a relatively scanty, short omentum. Perforation of a Meckel's diverticulum is more lethal than acute appendicitis with perforation, due to the greater volume and fluidity of the intestinal contents through a diverticular perforation. Overall perforation mortality is about 50 per cent.

Perforation occurs most commonly in the presence of the heterotopic gastric mucosa with adjacent peptic ulceration. It occurs in simple acute diverticulitis which progresses to gangrene and perforation, through the same pathological process as acute appendicitis with perforation. Perforation also occurs due to the lodgment in the diverticulum of foreign bodies. Wooden splinters, needles, fish bones, seeds, worms, and even gall stones have been reported as the cause of diverticular perforation.

Meckel's diverticulitis may be subclassified into non-specific types due to the presence of foreign bodies or parasites and the acute stages of inflammation similar to those associated with inflammation of the vermiform appendix. Specific infections of tubercular and typhoid etiology have been reported.

Acute Meckel's diverticulitis often completely simulates appendicitis. More frequently, however, instead of a shift of pain to the right lower quadrant, either there is no history of change in location of pain at all, or the change is toward some other part of the abdomen, coinciding with the location of the diverticulum at that time. Generally, there is more vomiting, more colicky pain, more marked febrile

lity, and greater abdominal distention than in appendicitis. Obviously these comparisons are so general, and so difficult to evaluate in a child, that the correct preoperative diagnosis is rarely made with any degree of regularity.

Third Most Common Complication

Intestinal obstruction is the third most common complication of the Meckel's diverticulum. It is the most common complication in the adult patient. The following are the most common types of obstruction:

1. Intussusception with the Meckel's diverticulum as the leading point.
2. A fibrous band between the tip of the diverticulum and the umbilicus compresses a loop of bowel and produces "closed loop" mechanical intestinal obstruction.
3. The diverticulum "knots around" the small bowel, usually ileum.
4. Incarceration of the Meckel's diverticulum in a pre-existing inguinal hernia (Littre's hernia).

The typical location of a Meckel's diverticulum is on the distal ileum within three and one-half feet of the ileocecal valve. However, in one large series, only 72 per cent were within three feet of the ileocecal valve, the most distant one being five and one-half feet from the cecum. It is, therefore, generally preferable to examine at least five or six feet of the distal ileum in order to exclude the presence of a diverticulum.

The average length of a typical diverticulum is three to five centimeters, although lengths up to 25.0 cm. are not extremely rare; there is a recorded case of a 95.0 cm. Meckel's diverticulum in an eight-year old female.

Type of Surgical Excision

The type of surgical excision is of interest and importance. Occasionally, it is acceptable to excise a diverticulum as one would perform an appendectomy, that is, with purse string suture inversion of the diverticular stump. Except for instances in which the base of the diverticulum is quite narrow, this method should be condemned for several reasons: stump inversion is made into an already relatively small lumen (as compared to the cecum), and thus may produce intestinal obstruction; inversion of a stump into an active fecal stream not only invites obstruction by simple luminal occlusion, but the inverted stump may act as a leading point for an intussusception. Further, heterotopic tissue is most

frequently found in the base, and should be completely excised.

Preferable Method for Excision

The preferable method for excision (Figure 2), includes the placing of two intestinal clamps obliquely transversely across the base, severance with actual cautery, and closure with interrupted non-absorbable Halsted or Lembert sutures. One such layer is usually sufficient. This method is practically aseptic, avoids the inversion of an excessive amount of tissue, and the transverse closure avoids constriction of the ileal lumen. It also allows for complete excision of the base of the diverticulum.

If the diverticular base is too thick to perform the above procedure, wedge resection of an ellipse of bowel with routine closure would be indicated. If the wedge resection was not considered applicable, segmental resection and end-to-end anastomosis would be the procedure of choice.

Whether or not to remove an incidentally discovered Meckel's diverticulum has been a controversial subject. In general, it is preferable that the diverticulum be removed when discovered, if this can be done without appreciable additional risk to the patient. The rationale for this is based on the following:

1. The chance for development of morbid pathology in a Meckel's diverticulum is ten times greater than in the vermiform appendix.
2. One out of five incidentally removed Meckel's diverticula contain gastric mucosa.
3. If the patient has previously had an appendectomy, or if incidental appendectomy is done at the time of laparotomy, incidental Meckel's diverticulectomy would avoid the unwarranted delay at a later date in operating on a patient with abdominal symptoms and signs of appendicitis with the knowledge that the appendix had been removed.

Many surgeons believe that the ileum should be inspected during every laparotomy in which this is feasible, particularly at the time of appendectomy when the appendix seems less grossly abnormal than the patient's preoperative clinical picture would suggest.

Mortality from symptomatic cases of Meckel's diverticulitis ranges between ten and 15 per cent. The overall mortality of cases of perforation is 50 per cent, a very significant figure.

Keener Awareness Needed

A keener awareness of this condition as a cause of lower gastrointestinal bleeding, particularly in children, and as a cause of a clinical picture similar

to appendicitis in both children and adults would tend to lower the mortality rate. Routine search for and prophylactic removal of Meckel's diverticula at laparotomy would further serve to reduce morbidity and mortality from this congenital anomaly.

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PRIVATE PHYSICIANS HALT SYPHILIS EPIDEMIC

ON APRIL 28, 1960, a Cobb County private physician reported a case of secondary syphilis in a 17-year old, colored female to the Venereal Disease Control Section, Georgia Department of Public Health. He granted permission for one of the trained Communicable Disease Investigators from the Health Department to interview this case for contacts, and for the next eight months a continuous chain of infection developed over a seven-county area with most cases occurring in four counties along the course of U. S. Highway 78.

Through intensive interviewing, re-interviewing, and investigation of named sex contacts, suspects, and associates by trained Communicable Disease Investigators from the Health Department, a total of 60 primary and secondary syphilis cases was brought to treatment. Fifty-six of these infectious lesion cases were diagnosed and treated by 22 private physicians in the seven-county area involved. Five of the 60 lesion cases were found in Carroll County, 19 in Haralson, 11 in Douglas, 20 in Cobb, two in Fulton, one in Hall, and two in Paulding. In addition, 14 cases of latent syphilis and one case of congenital syphilis were treated by these private physicians during the course of the epidemic.

The response and cooperation of the 22 private physicians concerned was spontaneous and without remuneration. Drugs were furnished by the Georgia Department of Public Health.

Since the closest Health Department Diagnostic and Treatment Center ranged from 22 miles at the nearest point to 75 miles at the farthest point, it would have been relatively impossible to control this epidemic through existing health department facilities, and the travel involved would have imposed undue hardship on the patients and suspects.

During the course of the epidemic, 1,330 contacts, suspects, and associates were named by the 60 lesion cases diagnosed and treated (22.54 per case). Of this number, 1,313 were located and examined—by the 22 private physicians involved. Since 38 per cent of the infectious cases were 20 years of age or younger and many of them attending high schools, the 1,563 students in the Negro high schools of the four principal counties involved were tested.

This epidemic is an outstanding example of what can

be done in venereal disease control by private physician and health department teamwork.

"Once again, I would like to take this opportunity to express my appreciation to the private physicians of Georgia for their splendid record of cooperation in venereal disease control.

"During 1960, 3,652 previously unknown and untreated cases of syphilis were reported to the Health Department. Private physicians diagnosed and treated 63 per cent of these cases. This represents a 17 per cent increase over cases reported for 1959. Most of the increase in Georgia was in the white population of (34 per cent) with only a 14 per cent increase in colored syphilis.

"Nine hundred twenty of the cases reported for 1960 were early lesion (primary or secondary) cases. This represents a 22 per cent increase in early lesion syphilis over cases reported for 1959 *but falls far short of the 53 per cent increase for the Continental United States over the same period of time.*

"All but three (99 per cent) of the 920 lesion cases were interviewed by trained Communicable Disease Investigators from the Health Department. The 917 infectious cases interviewed named an average of 22.88 contacts, suspects, and associates. Investigation of these contacts, suspects, and associates *was responsible for bringing to diagnosis and treatment 826 of the 920 early lesion cases reported for the year. No private physician case is interviewed without first obtaining the consent and cooperation of the physician concerned.*

"Since 1955 private physicians in Georgia have received one of our "Confidential Physicians and Hospital Venereal Disease Morbidity Report" forms on each reactive blood specimen submitted by them to public health or private laboratories. Over this period of time we have received better than 99 per cent response to our request for disposition on these reactive blood specimens. The essence of the above facts is this: *Venereal Disease Control in Georgia is a team effort on the part of private physicians and the Health Department.*"

John H. Venable, M.D., Director
Georgia Department of Public Health

THE EFFECTS OF THE COUMARINS ON THE CLOTTING MECHANISM

Nicholas E. Davies, M.D.; Grant Wilmer, M.D., and
Spencer Brewer, M.D., *Atlanta*

A patient may bleed profusely or, conversely, he may have a recurrence of his thrombotic episode even though the one-stage (Quick) prothrombin time is in "good range."

THE COUMARIN-TYPE ANTICOAGULANT drugs are now widely accepted as valuable agents in the treatment of many of the various thrombo-embolic diseases. Physicians using these drugs agree to their usefulness in certain specific conditions that have been carefully studied over a number of years. Occasionally, these agents cause mild or severe bleeding episodes. Fortunately, fatal hemorrhage is relatively rare, if one judges from the infrequent reports in the literature. Until the last few years it was customary to use anticoagulants for short periods of time, usually in a hospital under close supervision. More recently long-term anticoagulation has been used with increasing frequency, often with less close supervision, and, it is to be expected, with more frequent hemorrhagic complications.

We have recently seen three patients in whom serious bleeding episodes occurred while on long-term anticoagulant therapy and while each had a one-stage (Quick) prothrombin time in the generally accepted "therapeutic range." (To be reported.) These prompted a re-evaluation of the methods used in following our patients on anticoagulants and a review of the action of the coumarin-type drugs.

This paper is a summary of our current knowledge of the action of these drugs. It is not intended to discourage their use when indicated clinically.

Nomenclature and Acceptable Clotting Theory

During the past ten years tremendous advances have been made in our understanding of the complex

physiology of the clotting of blood. The language barrier that was formerly present was due to the inability to measure the various clotting factors except in terms of function or "activity." This barrier is now being broken as different workers have standardized measuring procedures. And now a standardized nomenclature (Figure 1) and an acceptable theory of clotting may be given (Figure 2-after I. S. Wright¹).

The Hagemen factor has never been associated with a hemorrhagic disease and can be identified only in the test tube. Plasma thromboplastin antecedent (PTA-Rosenthal) has not been clearly defined and is still under consideration for inclusion in this scheme. Several platelet factors and other first stage accelerators are under study and undoubtedly will be included at a future time.

FIGURE 1

I	Fibrinogen
II	Prothrombin
III	Thromboplastins (a) Lung (b) Brain (c) Platelet (d) Other tissues
IV	Calcium
V	Factor V (Owren); Proaccelerin (Owren); Labile factor (Quick)
VI	(None)
VII	Factor VII (Koller); Proconvertin (Owren); SPCA (deVries, Alexander); Stabile factor (Stefanini); others
VIII	Factor VIII (Koller); Antihemophilic Globulin (Patek and Taylor); AHF (Brinkhous); others
IX	Christmas factor (Biggs and MacFarlane); PTC (Aggeler); Antihemophilic Globulin B (Cramer); others
X	Stuart factor (Hougie); Factor X (Koller)

Action of the Coumarins

A great deal of detailed, sometimes ingenious work has been done in an attempt to define the action or actions of the coumarin-type anticoagulants, but as yet no precise answer is available. Indeed, the action of Vitamin K, which the coumarins theoretically inhibit, is unknown. Recently, it has been suggested that this vitamin may activate oxidative phosphorylation and serve as a coenzyme for the synthesis of prothrombin by the liver.² It would follow that the coumarins might inhibit this mechanism, but as yet, this can only be speculative.

It is known that certain of the factors essential for the normal clotting of blood are depressed by the administration of coumarin anticoagulants. These are: Factor II (prothrombin); Factor VII (proconvertin); Factor IX (Christmas); Factor X (Stuart). A brief summary of our present knowledge of these factors is now presented.

1. *Factor II* (prothrombin). This is a protein physiochemically resembling albumin, having a molecular weight of 62,700 and found in blood at an approximate concentration of 20 mg. per cent.³ Factor II concentration can be determined fairly accurately by two-stage methods,^{4,5} but it is *not* of primary importance in altering the one-stage (Quick)* prothrombin time of patients on anticoagulants. This component of normal plasma is relatively stable at room temperature, is "consumed" almost completely in the normal production of thrombin (and, therefore, absent from serum), and is adsorbed by barium sulfate and aluminum hydroxide. It is produced by the normal liver in the presence of adequate amounts of Vitamin K, although the latter does not become incorporated into the prothrombin molecule. It is decreased in the blood when adequate amounts of Vitamin K are not absorbed (obstructive jaundice, steatorrhea from various causes, etc.), when Vitamin K utilization is depressed (severe liver disease), when Vitamin K action is blocked (the postulated action of the coumarin anticoagulants), and, quite rarely, idiosyncratically.⁶

Clinicians have observed for a number of years the sometimes poor correlation between the one-stage (Quick) prothrombin time and the incidence of bleeding in their patients on coumarin anticoagulants. Originally, this was generally ascribed to improper technique in performing the Quick test. Later it was learned that the Quick test was a more sensitive measurement of Factor VII (proconvertin) than of Factor II (prothrombin). It seemed likely that these patients were bleeding from a deficiency

of Factor II, which the Quick test could measure only if the thromboplastin used by the laboratory was free of Factor VII. Recent well controlled studies^{7,8,9} of patients on coumarin-type anticoagulants found poor correlation between the Quick time and the Factor II (prothrombin) concentration. In those patients who bled, there was a very close relationship between the actual Factor II *content* as determined by two-stage methods and the bleeding episode. This, then, can explain why in certain instances a patient may bleed profusely or, conversely, why he may have a recurrence of his thrombotic episode, even though the one-stage (Quick) prothrombin time is in "good range."

2. *Factor VII* (Proconvertin). All of the known, and many of the postulated properties of this component of normal blood have been summarized in an excellent paper by Alexander.¹⁰ As yet, Factor VII has not been completely isolated, and its composition and structure defined. Its many known properties indicate that it is a protein which is quite stable at room temperature and with time, and that it is not "consumed" during the clotting process and therefore is present in serum. Factor VII is adsorbed by barium sulfate and Seitz asbestos filters. Like Factor II (prothrombin), it depends on adequate amounts of Vitamin K and a relatively normal liver for its production. Hereditary Factor VII deficiency, unlike Factor II, is not too uncommonly seen as a non-sex linked hemorrhagic disease. Factor VII is more quickly and more profoundly reduced than Factor II by the coumarin-type anticoagulants,^{9,11} and, with the administration of Vitamin K, it more quickly returns to normal levels. The two-stage method of Owren⁴ measures Factor VII more accurately, and recent evidence indicates that it is also measuring Factor X (Stuart).¹⁰

Certain commercial tissue thromboplastins that are used by clinical laboratories in one-stage (Quick) prothrombin time determinations contain appreciable amounts of Factor VII (proconvertin), depending on their source and purification. One of us (S. B.)* has found that much variation exists among many of the commercially available thromboplastin preparations insofar as Factor VII activity is concerned. This variation among thromboplastins quite obviously is not desirable, and it is necessary to avoid the use of a reagent which contains the factor that is being tested. We may not know exactly what we are measuring with the Quick test in a given situation, but it is important that the test be as consistent as possible.

3. *Factor IX* (Christmas factor; PTC). This is a relatively stable constituent of normal plasma and serum that was discovered by Biggs, et al,¹² and first

*This test is widely performed. To the patients decalcified plasma is added measured amounts of calcium and a commercial thromboplastin substance, the latter usually prepared from rabbit brain. The appearance of a clot is the endpoint and usually is between 12 and 14 seconds.

*To be published.

reported in 1952. It, too, is adsorbed by barium sulfate and aluminum hydroxide and, like Factor VII (proconvertin), is not “consumed” with clot formation. An hereditary deficiency of this factor, formerly thought to be a mild form of “classical” hemophilia (Factor VIII ((AHG)) deficiency), has been well defined through the use of the thromboplastin generation test.¹³ This test has also been instrumental in elucidating other factors necessary in the first stage of clotting: i.e., Factor X (Stuart) and plasma thromboplastin antecedent.

A deficiency of Factor IX (Christmas) does *not* affect the one-stage (Quick) prothrombin time because this factor is concerned with the production of Factor IIIc (thromboplastin) in the first stage of clotting (Figure 2). In the Quick test, tissue thromboplastin is added (as is Factor IV (calcium)) to the plasma being tested and therefore Factor IX is not needed for clot formation in this procedure. However, a severe deficiency of Factor IX does prolong the Lee-White clotting time since thromboplastin generation is accelerated by this factor and, therefore, it is essential for the normal course of the first stage of clotting (as noted in Figure 2).

Sise, et al,¹⁴ noted a prolonged glass clotting time in patients who had been on coumarin-type anticoagulants for over 30 days. In studying this observation, they found that the plasmas of these patients failed to correct the defect in the consumption of prothrombin in people with hereditary Factor IX (Christmas) deficiency. The thromboplastin generation test confirmed the deficiency in Factor IX in patients on coumarin-type anticoagulants, and others have noted the same effect with these drugs.^{15,16,17,18}

Greig¹⁸ records the death of a woman following cardiac surgery who had been anticoagulated with phenidione (Hedulin,[®] eridione), and who was in “good therapeutic range.” She was heparinized prior to surgery. She subsequently oozed despite large doses of protamine sulfate. Appropriate studies found a marked deficiency of Factor IX (Christmas). Greig states that both heparin and the coumarin-type drugs will depress Factor IX and warns that patients on long-term anticoagulation,

prior to heparinization, should have their anticoagulants stopped for at least a week before open-heart surgery is done.

4. *Factor X* (Stuart factor). This clotting factor has recently been accepted by the International Committee for the Standardization of the Nomenclature of Blood Clotting Factors. Factor X (Stuart) is important in both the first *and* second stages of clotting. Its absence gives both a defective thromboplastin generation (first stage, Figure 2) and a prolonged Quick time (second stage, Figure 2). Its deficiency was first identified by Hougie, et al,¹⁹ in a family in North Carolina whose name was Stuart. Certain members of this family had epistaxes, hemarthroses, and other bleeding phenomena. Hougie’s detailed studies found that a deficiency in Factor X was inherited in the Stuart family as an incompletely recessive autosomal characteristic with a high degree of penetrance. Hougie also made the observation that the plasma of people on Dicumarol[®] anticoagulation “at a later stage of treatment” was deficient in this (Stuart) factor.

Duckett, et al,¹⁵ describe how Koller suspected his “Factor X” (now judged to be identical with the Stuart factor) to be deficient in patients on Dicumarol[®] and marcoumar (phenprocoumon). They also noted a deficiency in certain patients with hepatitis and cirrhosis.

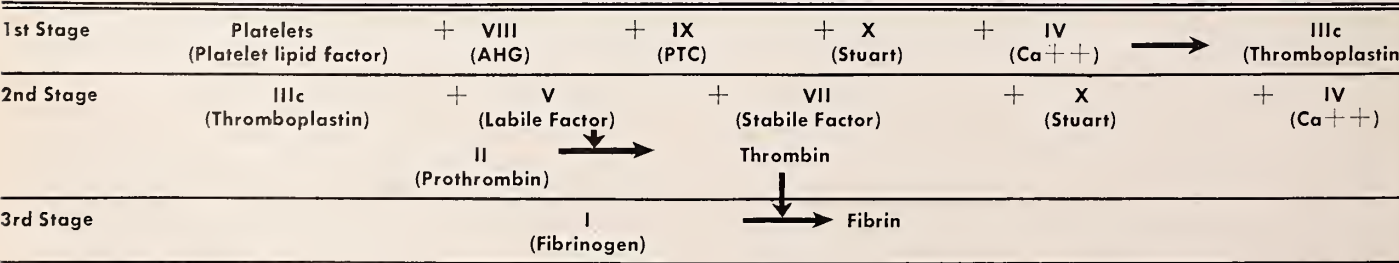
Discussion

No attempt will be made to discuss and compare the numerous drugs of the coumarin-type that are now available commercially. To our knowledge no study has been done under varying controlled conditions with any of the commonly used coumarin-type anticoagulants, although the work of Johnson, et al,¹⁷ approaches this. Conversely, there has been no recent study comparing the action of several of the commonly used anticoagulants on the individual clotting factors.²⁰ A study of this type is needed for the rational use of these potent drugs.

It is interesting that all of the clotting factors affected by the coumarin-type drugs are adsorbed by barium sulfate. The significance of this observation is as yet unknown but perhaps when it is explained the action of these drugs will be clarified.

At present it is common practice to use the one-

FIGURE 2
CLOTING IN WHOLE BLOOD



stage (Quick) prothrombin time for the control of anticoagulant therapy. As noted above this test measures primarily Factor VII. Some commercial thromboplastins do not measure consistently the other three factors influenced by the coumarins: Factor X, Factor IX, and Factor II. It remains a fairly satisfactory test for estimating the proper dose of coumarin anticoagulant for two reasons: (1) it is simple to perform and (2) the depression of the other three factors usually parallels that of Factor VII. It is in the occasional patient in whom this parallel does not exist that the physician gains a false sense of security and it is usually in such patients that one encounters hemorrhage or insufficient anticoagulation.

The two-stage test⁹ of Owren can be a more accurate test of coumarin induced anticoagulation, but it has not been used as widely as the Quick test because of economic factors. It is subject to the same basic disadvantages as the Quick test, but has the advantages of eliminating Factor V as a variable, and providing an excess of fibrinogen to allow a more clearly defined end point.

It seems likely that the Quick test will soon be replaced by one of the newer procedures. The "Thrombotest" reagent recently introduced by Owren^{21,22} appears to be a superior thromboplastic substance. This reagent detects diminished coagulability due to a deficiency of any of the four factors affected by the coumarin drugs—Factors II, VII, IX, and X. This "all-in-one" reagent is made of four ingredients: (1) crude cephalin; (2) animal thromboplastin (which has a low activity with human factor VII); (3) adsorbed bovine plasma, freed of the four factors concerned, and (4) calcium chloride. This reagent is not yet produced in this country but may be obtained from Nyegaart and Company, Oslo. Early experience with the reagent shows it to be accurate, easily used, and relatively inexpensive. Either capillary or citrated venous blood may be tested.

Thrombelastography

Thrombelastography is a new method of studying coagulation. Here the time of formation of the clot and the elasticity of the clot as it forms are kymographically recorded. This method yields valuable information but at present is not suited for use in a clinical laboratory. The test is not specific for the four factors affected by the coumarins but characteristic patterns are obtained which correlate with the degree of induced anticoagulation.

Summary and Conclusions

Occasionally, serious problems have resulted

from the use of the coumarin-type anticoagulants. A better understanding of the effects of these drugs on the clotting mechanism and improved methods of testing these effects will reduce the hazards of anticoagulant therapy.

The known actions of the coumarin drugs are reviewed and the four blood factors affected by these drugs are discussed. The various tests available for determining their action on the clotting mechanism of the blood are reviewed. Serious consideration should be given to more stringent selection of the thromboplastic substances used for determining the effects of the coumarin-type drugs.

Medical Arts Building

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PRELIMINARY PLANNING FOR BUILDING PROGRAM

PRELIMINARY PLANNING FOR a vast building program currently is under way at the Medical College of Georgia in Augusta. The plans are aimed at providing both new and expanded facilities to step up several phases of the college curriculum. University System interest has been evidenced through encouragement by the Board of Regents.

Further development of the plans hinge on the availability of a 29-acre tract of land immediately adjacent to the Medical College campus which, because of a high incidence of sub-standard housing, has been declared an Urban Renewal Area. At the request of the college administration, the City of Augusta has agreed to act as Local Public Agent (LPA) in efforts to secure the land for educational purposes.

In February, Senator Herman Talmadge announced that a \$55,926 grant had been awarded to begin survey and planning activities as the first step toward acquisition of the land. At the same time, it was revealed that a federal capital grant of \$596,334 has been earmarked for purchase of the property. Under Urban Renewal, each dollar of local participation is matched by two dollars of federal aid, with the ultimate local cost being several hundred thousand dollars lower than appraised property value.

Despite a low reservoir of funds for such programs, the Medical College Urban Renewal Project has been given a high priority by Washington. It is one of the first proposals of its kind to receive governmental approval and is expected to help establish a precedent for similar programs in other states.

Regional authorities of the Housing and Home Finance Agency (HHFA, Urban Renewal, etc.), in concurrence with city officials, have estimated that initial purchases of property in the Urban Renewal area can

commence this Spring. The entire 29 acres may be available for use by the school within a two-year period.

Dr. Harry B. O'Rear, President of the Medical College of Georgia, has stated on many occasions that acquisition of additional land is a prerequisite to future growth of the institution. The 30 acres now owned by the college are occupied by nine buildings in which are located the basic science and clinical departments of the School of Medicine, and the classrooms and living quarters for the School of Nursing. More facilities are necessary, says Dr. O'Rear, if medical education is to keep pace with Georgia's rapidly growing need for personnel in the medical and paramedical professions. Anticipating future requirements, he has proposed a long-range program which includes construction of a new library, a student union building, additional laboratory and classroom space, and student housing.

The government's chief interest in Urban Renewal is the demolition and clearance of sub-standard housing, and the re-location of displaced families in more desirable homes. Its secondary interest is the re-use of property obtained via Urban Renewal. The Medical College Urban Renewal Project, which can result in an expanded program for the education of more doctors, nurses, medical technicians, medical librarians, occupational and physical therapists, nutritionists, and others in the health professions, falls in line with the government's acknowledgment of a great and growing need for the expansion of educational resources.

Federal concern is partially the result of population growth projections. In Georgia alone, it is predicted that the number of residents will more than double in the next four decades. Current state population, according to the 1960 census, is 3.9 million. By the year 2000, it is expected to be 8.5 million. If even present-day standards are to be met 40 years hence, a dramatic acceleration of educational facility construction is considered an emphatic must.

In Georgia, major Medical College growth has taken place recently. Within the past few years, the school has re-located almost completely in new and more spacious structures. Replacing the old Newton Building, which will be remembered fondly by many graduates of the school, are the Murphey and Dugas Buildings where many of the basic science departments are located. Clinical departments are housed in the Eugene Talmadge Memorial Hospital, and construction was completed earlier this year on a large new research wing which is to serve most of the school's departments.

Much progress already has been recorded. With the availability of more land, the door will be opened for additional growth which will enable the Medical College of Georgia to offer even greater programs of medical education and training than at present.



The present 30-acre campus of the Medical College of Georgia is bounded by a solid line. The 29-acre area which the Medical College hopes to acquire via an Urban Renewal project is enclosed with a dotted line.

1961-62 CALENDAR OF MEETINGS

State

- June 7-9—Georgia Board of Medical Examiners, Examination and Endorsement, Atlanta and Augusta.
 June 11-14—Georgia Pharmaceutical Association, Biltmore Hotel, Atlanta.
 July 10-28—Emory University's School of Nursing, short-term, intensive courses, Emory University, Atlanta.
 Sept. 8-9—Thirteenth Annual Meeting, Georgia Heart Association, Jekyll Island.
 Oct. 12-14—Georgia Academy of General Practice, Annual Session, Jekyll Island.
May 6-9—Annual Session, Medical Association of Georgia.

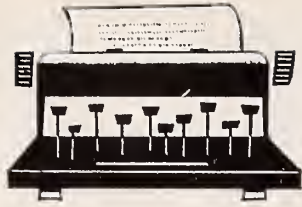
Regional

- Sept. 19-21—Kentucky State Medical Association, Brown Hotel, Louisville, Kentucky.
 Sept. 25-26—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tennessee.
 Nov. 6-9—Southern Medical Association, Municipal Auditorium, Dallas, Texas.
 Dec. 5-7—Southern Surgical Association, Hot Springs, Virginia.

National

- May 25-27—American Gastroenterological Association, Drake Hotel, Chicago, Illinois.
 May 29-31—American Gynecological Society, The Broadmoor, Colorado Springs, Colorado.
 May 31-June 3—University of Colorado Medical Center, Postgraduate Course, Denver, Colorado.
 June 5-23—46th Annual Meeting, Trudeau School of Tuberculosis, Saranac Lake, New York.
 June 12-14—American Neurological Association, Hotel Claridge, Atlantic City, New Jersey.
 June 14-17—Society of Nuclear Medicine, Penn Sheraton Hotel, Pittsburgh, Pennsylvania.
 June 19-23—Postgraduate Course in Current Aspects of Internal Medicine, State University of Iowa College of Medicine, Iowa City, Iowa.
 June 22-23—American Geriatrics Society, New York, New York.
 June 22-24—Endocrine Society, Hotel Biltmore, New York, New York.
 June 22-26—American College of Chest Physicians, Hotel Commodore, New York, New York.
 June 24-25—American Diabetes Association, Commodore Hotel, New York, New York.
June 26-30—American Medical Association, Annual Meeting, New York, New York.
 July 2-7—American Physical Therapy Association, Palmer House, Chicago, Illinois.
 July 10-13—University of Colorado School of Medicine, Postgraduate Course, Estes Park, Colorado.
 July 24-28—American College of Chest Physicians, Postgraduate Course, Brown Hotel, Denver, Colorado.
 Sept. 8-Nov. 10—New York University Postgraduate Medical School, Occupational Medicine, New York University Medical Center, New York, New York.

- Sept. 23-30—University of Illinois College of Medicine, Annual Otolaryngologic Assembly, Chicago, Ill.
 Sept. 25-28—American Hospital Association, Atlantic City, New Jersey.
 Sept. 25-29—American College of Chest Physicians, Postgraduate Course, Warwick Hotel, Philadelphia, Pennsylvania.
 Sept. 26-29—American Roentgen Ray Society, Deauville Hotel, Miami Beach, Florida.
 Sept. 28-30—American Association for the Surgery of Trauma, Drake Hotel, Chicago, Illinois.
 Sept. 30 - Oct. 3—College of American Pathologists, Seattle, Washington.
 Sept. 30-Oct. 8—American Society of Clinical Pathologists, Olympic Hotel, Seattle, Washington.
 Oct. 1-7—College of American Pathologists, Olympic Hotel, Seattle, Washington.
 Oct. 2-5—American Academy of Pediatrics, Palmer House, Chicago, Illinois.
 Oct. 2-6—American College of Surgeons, Conrad Hilton Hotel, Chicago, Illinois.
 Oct. 8-13—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Illinois.
 Oct. 15-20—Fourth International Congress of Allergology, the Hotel Commodore, New York, New York.
 Oct. 20-24—34th Annual Meeting, American Heart Association, Miami Beach, Florida.
 Oct. 22-25—American College of Gastroenterology, Hotel Cleveland, Cleveland, Ohio.
 Oct. 22-27—American Society of Anesthesiologists, Inc., Statler Hilton, Los Angeles, California.
 Oct. 23-27—American College of Chest Physicians, Postgraduate Course, Sheraton-Chicago Hotel, Chicago, Illinois.
 Oct. 25-29—American Society of Clinical Hypnosis, St. Louis, Missouri.
 Nov. 13-17—American College of Chest Physicians, Postgraduate Course, Park Sheraton Hotel, New York, New York.
Nov. 27-30—American Medical Association, Clinical Meeting, Denver, Colorado.
 Dec. 4-8—American College of Chest Physicians, Postgraduate Course, Statler-Hilton Hotel, Los Angeles, California.
 Jan. 27-Feb. 1—American Academy of Orthopaedic Surgeons, Palmer House, Chicago, Illinois.
 Jan. 29-Feb. 1—American College of Surgeons, Four-Day Sectional Meeting for surgeons and graduate nurses, Statler-Hilton and Biltmore Hotels, Los Angeles, California.
 Feb. 5-7—American Academy of Allergy, Denver-Hilton Hotel, Denver, Colorado.
 Feb. 7-10—American College of Radiology, Roosevelt Hotel, New York, New York.
 April 2-5—American College of Obstetricians and Gynecologists, Palmer House, Chicago, Illinois.
 April 6-13—American Academy of General Practice, Las Vegas, Nevada.
 April 30-May 2—American Academy of Pediatrics, Statler-Hilton, New York, New York.



editorials

A Salute to Our Hospitals

NOT TOO MANY YEARS ago, people were of the opinion that if you went into a hospital you were "headed for the last round-up." A hospital was a place to go when everything else failed and you were just about ready for the morgue. If you were not quite ready, people felt the hospital would help you to get ready.

These opinions have changed considerably so that today one out of each eight Americans, about 23 million people, is expected to enter a hospital this year. Why this change?

The hospital has become such an integral part of medicine through medical education of doctors, nurses, and medical technicians. Medical research, although originally conceived and tried in the laboratory, is ultimately given its clinical application in the hospital. Hospitals are also research centers for more efficient and cheaper administrative procedures.

The hospital can not properly operate without its medical staff, but all too often we do not stop to think that it also can not survive without the administration and ancillary personnel. The majority of us do not remember when we did not have all of this "help" in running the hospital, but let us pause and reflect as to what kind of hospital we would have if "I had to do it *all*." With today's myriad tests and complicated procedures, it would be practically impossible.

There are so many things our colleagues of the administrative staff, trustees and governing body, other professional staffs, ancillary staff, as well as

the volunteer workers, are doing to give the best possible care for the most important person in the hospital—the patient.

Now things are in favor of the hospital—an immense segment of medical practice. The hospital is now held in the highest esteem. Will this high opinion always remain?

We should keep the hospital as economical as possible and refrain from extravagance, waste, and misuse of material. Each physician should feel responsible for not only the highest type of medical care but as economical medical care as possible.

The hospital should be concerned with political influence only when the individual patient will benefit. Often this is not so; therefore, as far as possible the hospital, including its personnel, should not be under any political control. Unfortunately, due to the rising cost of medical care, too many hospitals are used as political media. If this progresses too far, the image may shift to the hospital's detriment, and the patient will suffer.

The Medical Association of Georgia salutes the Georgia Hospital Association and the hospitals we have throughout the State of Georgia, their governing boards, administrative staffs, and ancillary personnel. May close cooperation of all continue, and if so, the patient will be the one to profit most.

*Milford B. Hatcher, M.D.
Immediate Past President,
Medical Association of Georgia*

New Assistant Executive Secretary

EXECUTIVE COMMITTEE OF MAG Council was pleased to announce to the membership the employment of Mr. James Mincy Moffett as Assistant Executive Secretary on the Headquarters Office staff effective February 1, 1961.

A true "grass roots" Georgian, Mr. Moffett graduated from the University of Georgia after being reared in Dublin. Upon completion of military service, Mr. Moffett assumed the position of secretary to the Hon. James C. Davis, Member of Congress representing the Fifth Congressional District, Georgia.

Married to the former Ann Charlotte Stevens of Columbus, Georgia, Mr. Moffett had established residence in Washington, D. C., and Decatur, Georgia. With the recent advent of a son, James M. Moffett, Jr., Mr. Moffett chose to establish permanent residence in Georgia and applied to MAG for the vacancy created by the recent resignation of former Associate Executive Secretary, John F. Kiser.

Staff responsibilities for this position included a knowledge of "legislative know-how;" public relations ability; public speaking talent, and most important a capability in field service liaison with MAG county medical societies.

Mr. Moffett has been active in the DeKalb County Junior Chamber of Commerce, the University of Georgia Alumni Society, and is a member of the



MR. JAMES M. MOFFETT
Assistant Executive Secretary
Medical Association of Georgia

First Presbyterian Church of Decatur, Georgia.

In the short three months that Mr. Moffett has been with MAG, he assumed staff leadership of local and national legislative activity. In his capacity as Assistant Executive Secretary, he has addressed both medical and civic meetings on MAG policy matters. Already he has participated as staff to many MAG committees.

The Association and its membership welcome Jim Moffett as "true Georgia"—dedicated to MAG aims and endeavors.

Blood Pressure and Life Insurance

IF PHYSICIANS THINK THAT they or their patients can buy life insurance at standard rates with a blood pressure of 145/90, they are due for a shock. Now, men under 39 with blood pressure readings of 140/86 will find themselves paying higher than normal premiums to many of the largest and oldest insurance companies now.

The reason for this change in rating of blood pressure is the result of a mammoth study of "Build and Blood Pressure," published in October 1959 by the

Society of Actuaries. They reviewed 3.9 million policies issued between 1935 and 1953 by 26 leading American and Canadian life insurance companies. The effects of slightly increased blood pressure and/or overweight on mortality were studied. There were 102,000 deaths in this group and they found that "slightly elevated" blood pressure was associated with an increased mortality from renal, heart, or cerebrovascular disease. The deaths due to accident, cancer, and infections were no greater than

expected from standard mortality tables. For example, males between the ages of 30-39 with a diastolic BP between 88-92 mm. Hg. showed a 199 per cent mortality (twice as many died as expected during the 18-year period of study) and died from the expected complications of severe hypertension. As a result the leading companies have issued new "normal" tables for blood pressure according to age, sex, and height of diastolic and systolic pressures. These are much more stringent than those previously used.

What does this mean to physicians as contrasted with medical underwriters? We know (as did the medical actuaries) the various errors involved in the indirect measurement of blood pressure with the sphygmomanometer: (1) arm size, (2) pulse rate, and (3) tendency to report in round figures, as well as the numerous physiological factors causing minute to minute changes in the actual values.

One unknown factor, however, is what I have called "the physician fudge factor"—how many points has the examining physician deducted because he thinks 10 or 15 mm. are not significant or are due to "tension."

There are two possible conclusions from this study:

(1) Small elevations in blood pressure are indeed significant and are associated with a decreased life expectancy, or

(2) The insurance companies are not getting honest reports, especially with the group of young men in the 135-145 over 85-95 blood pressure range.

In the past the insurance industry figures have been a main source of normal medical values. This still holds true with height, weight, and other easily measured parameters. The medical profession will have to decide for itself whether it has misled the insurance industry with regard to "high blood pressure."

Joseph A. Wilber, M.D.

DOCTORS AT A.M.A CONVENTION TO SEE INTERNATIONAL MEDICAL FILM EXHIBITION

A SPECIAL SCIENTIFIC feature at the 110th annual meeting of the American Medical Association in New York City, June 25-30, will be a series of outstanding medical films from all parts of the world.

This second U.S. International Medical Film Exhibition is being coordinated by the A.M.A. Department of Medical Motion Pictures and Television in cooperation with Johnson and Johnson for showing in Room C of New York's big Coliseum during the convention.

"We are pleased to participate again in this important phase of postgraduate medical education," said Dr. John Henderson, medical director of Johnson and Johnson. "These carefully selected films, covering practically every specialty of medicine, represent a fine medium for the continuing education of the busy practicing physician," he said.

More than 50 medical films will be shown and, in many instances, the film's author will be present to answer questions from the attending physicians. More than 30 of the films will be from foreign countries.

For the first time in the history of medical meetings, the film exhibition will include a number of film forums in which international medical experts will participate as panelists. One such film forum will cover selective coronary cinearteriography. Others will deal with neurological examination of children, and obstetrics and gynecology.

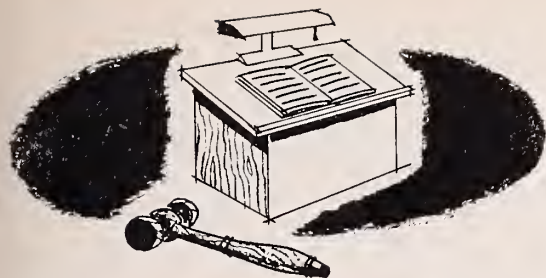
Other films will give a pictorial summary of medical missionary activities in Africa, India, and other parts of the world.

Among the subjects to be covered in the films and the authors will be:

"External Cardiac Massage" by Dr. James Jude and a group of physicians from Johns Hopkins Hospital, Baltimore; "Pediatric Gynecology" by Drs. Rudolf Peter and Karel Vesely of Prague, Czechoslovakia; "Procedure of Choice in Duodenal Ulcer Problems" by Dr. R. Cameron Harrison, Edmonton, Alberta, Canada; "Anterior Fusion in Spinal Tuberculosis" by A. R. Hodgson, Hong Kong, China, and "Life with a Substitute Bladder" by Drs. James W. Merricks and R. K. Gilchrist, Chicago.

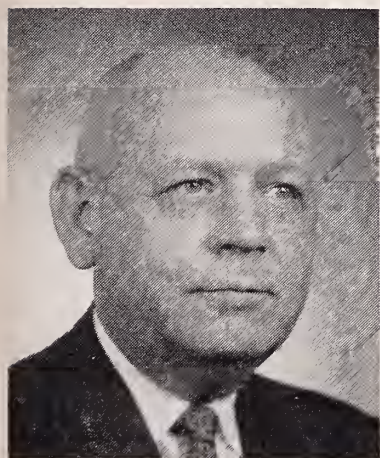
"The American Medical Association is happy to present these outstanding films to its members," said Dr. F. J. L. Blasingame, executive vice president of the A.M.A. "The exhibition points the way toward better medical procedure through teaching, thus helping the doctor in his daily practice."

Information about the film exhibit may be obtained from Ralph Creer, Department of Medical Motion Pictures and Television, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.



president's letter

NEW FRONTIERS FOR MEDICINE



FRED H. SIMONTON, M.D.

THE HISTORY OF AMERICAN politics is replete with examples of how elections have been won by the smallest possible majorities. The most dramatic illustration of this point was the fateful election of 1800 in which Thomas Jefferson was elected third President of the United States by a single vote cast in the House of Representatives.

There is a principle involved and a lesson to be learned from this moment in history. The principle simply stated is that each of us has the power to be an effective force which could change the course of history if only that power could be harnessed. The lesson to be learned is that a single vote, a single voice, a singular effort can be the difference between victory and defeat.

The contributions of the medical profession to the advancement and to the everlasting benefit of humanity are too numerous to mention. In the past sev-

eral hundred years the medical profession has advanced from the snake pits of human misery to the summit of scientific accomplishment. We now camp on the threshold of medical breakthroughs thought to be impossible a decade ago. The new frontier for medicine, like frontiers in days past, hold great promise. We have in our grasp the means and the talent to lift mankind out of the darkness and to give hope where none had existed. Such is the history of the medical profession, but what of the future?

The American medical profession faces the most perilous time in its history. Powerful political blocks are now engaged in an all out campaign to saddle the burden of stringent government control on the free practice of medicine. To resist this encroachment will require the best efforts of each of us. At this point the battle is one that chiefly concerns itself with the medical profession. In a larger sense, it is a battle which addresses itself to every person determined that his birth right shall not be sacrificed on the altar of political expediency.

Organized medicine has an obligation, not only to itself, but also to the American people to bitterly resist bureaucratic strangulation which government control would impose. This will not be a comfortable fight nor will victory be easily achieved, however, the victory can be ours if we are willing to make the effort. I cannot overstress the fact that we must all join in the fight to preserve the freedom of the medical profession. This is not a responsibility that can be abdicated. It is not one that can be delegated. Rather, each of us must assume our rightful place in the defense of our right to practice medicine free from overburdensome federal regulations.

Every right carries with it an equal responsibility. This is as true in medicine as in every field of hu-

PRESIDENT'S LETTER / Continued

man endeavor. Medicine's right to practice in unmolested freedom is accompanied by medicine's responsibility to provide the best possible medical care for all people. The public interest is at stake and their well being is paramount. To interpret this public trust and relate it to the responsibility, which the practitioners of medicine owe to the profession, requires that each of us recognize our *individual* responsibility in the fight to resist government control. To do this we must all take time, no matter how busy our schedules, to inform our patients of the effects which government medicine will have on their health. We should not overlook this opportunity to tell the doctor's side of the story. Working through our local county medical societies, we must inaugurate a broad public information program. For only if the public has the true facts can they make a righteous decision. In the end it will be their decision which shall prevail.

There are approximately 3,000 members of MAG in a state which has nearly four million people. In light of these statistics, it is apparent that physicians

acting alone lack the numerical strength to be a strong political entity, but, because our position regarding medical care for our senior citizens is right, we have attracted a large following. This is as it should be, because in essence the fight to preserve medical freedom is actually the fight to protect the health of the people. On this premise we should encourage our friends to join with us in our fight to prevent bureaucratic control of the practice of medicine from Washington. Many have indicated their willingness and need only leadership from doctors.

If we fail in this fight, we not only do a great disservice to ourselves, but to all the men of medicine who will follow us. We may have to win this fight many times, but we can lose it only once.

Permit me to repeat that this is a matter which addresses itself to us all. It requires our *best* efforts; it requires our *constant* efforts. If we fail, it will matter little what we do in the future.



President, Medical Association of Georgia

AMEF CONTRIBUTORS

<i>Name</i>	<i>Address</i>
Adair, M. C.	Washington
Austin, Jack L.	Griffin
Austin, W. H.	Griffin
Baxley, Warren	Blakely
Cheves, H. L., Jr.	Union Point
Cheves, H. L., Sr.	Union Point
Coffee County Medical Society, Woman's Auxiliary	Douglas
Crowdis, James	Blakely
Duggan, D. A.	Washington
Duncan, G. A.	Decatur
Fisher, William R.	Atlanta
Fowler, Ralph W., Jr.	Marietta
Fowler, Ralph W., Sr.	Marietta
Hagood Murl M.	Marietta
Harper, W.	Warrenton
Holland, S. P.	Blakely
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McClure, E. R.	Marietta
Merritt, Hinton	Colquitt
Merritt, James	Colquitt
Muscogee County Medical Society, Woman's Auxiliary	Columbus
Pittman, Oliver C.	Commerce
Pittman, Carl S., Jr.	Tifton
Pittman, Carl S., Sr.	Tifton
Powell, F. C.	Avondale Estates
Rentz, Turner	Colquitt
Rhyne, W. P.	Albany
Richmond County Medical Society, Woman's Auxiliary	Augusta
Schmidt, Fred	Marietta
Shull, Elliott	Fort Stewart
Simpson, A. W., Jr.	Washington
Smith, W. P.	Stone Mountain
Wall, W. H.	Blakely
Wetherby, David	Fort Gaines
Wills, Charles	Washington
Wood, Homer	Fort Gaines



mental health page

HOMOSEXUALITY

William Rottersman, M.D., *Atlanta*

HOMOSEXUALITY IS AN extremely important psychological, medical, and social problem. A conservative estimate is that about two per cent of men are permanently homosexual. We should not confuse homosexuality and homosexual behavior. A high percentage of men and women have at some time in their life a homosexual experience. A homosexual act or a brief period of homosexual behavior is not unusual during phases of personality development in the non-adult. An individual should be designated as homosexual only if the preferred sexual object is a member of the same sex and there is an absence of attraction for members of the opposite sex. Homosexuals differ markedly in their preoccupation with and need for homosexual activity. At one extreme is the male homosexual whose chief concern is the company and attention of "gay" boys and who frequently seeks physical homosexual activity. There are many homosexuals who never engage in homosexual physical behavior.

Human beings are born usually with such capacity to develop and mature as will permit them in time to assume an adult biological and social role in life. Most psychiatrists assume that the homosexual individual was endowed at birth with the personality capacities for normal development, but that highly disturbing emotional trauma or conflicts in early life caused distortions or failure in the development of the personality. Factors similar to those that produce a neurosis operate in the causation of perversions such as homosexuality. The term "homo-

sexuality" is as broad as the term "neurosis." Its meaning varies with different personality types. Unconscious phantasies and conflicts are responsible for the persistence in adulthood of homosexual behavior.

Many different factors may contribute to the production of homosexuality. For the male some of these factors are a lack of love for the mother because of her absence, coldness, domination or unpleasant personality; abnormal closeness and excessive affection between mother and son; hostility to a cold, brutal or threatening father; a father who is passive or lacking in masculine attributes and, therefore, an inadequate father with whom to identify. Physical and constitutional factors may be contributory, but homosexuality is primarily a psychological disorder.

Many homosexuals, apart from their concealed sexual deviation, lead respectable and constructive lives. From Sophocles through Leonardo da Vinci to Marcel Proust, history provides us with the names of many notable people who it appears were homosexually inclined. However, most homosexuals, because of their arrested development, are unable to cope with life's stresses and are inclined to be irritable, readily discouraged, often depressed, and suicidal. Some are delinquent, alcoholic, and criminally inclined. Most homosexuals are seriously maladjusted individuals for whom at present no treatment offers the prospect of cure. Psychotherapy may alleviate or remove disturbing neurotic symp-

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

toms. Psychotherapy may help the homosexual to better adjust to social realities without changing his attitude or behavior.

Neither endocrine preparations, drugs of any sort nor surgery appear to be of any value in the treatment of the homosexual. This is not surprising if we accept the prevailing thinking that homosexuality is environmentally determined rather than due to constitutional or endocrine factors. Psychotherapy, particularly psychoanalysis, may prove of value in carefully selected patients. The homosexual who may be amenable to treatment voluntarily seeks

therapy because of a desire to change and a feeling of guilt concerning his behavior. The homosexual who seeks treatment because of a fear of exposure and social disgrace usually has inadequate motivation for therapy.

There are some men and women who should never marry because of the nature of their sexual drive. Marriage does not help the disorder of the homosexual. Unfortunately, many latent and overt homosexuals do marry, their perversion unknown, at least for a time, to their partner. Since homosexuals abhor close contact with members of the opposite sex and feel little or no sexual desire for their mates, these marriages are at best unsatisfactory and usually tragically unhappy.

EXCERPTS FROM "GOOD EVENING" BY QUIMBY MELTON

MARCH 30TH, PHYSICIANS, living and deceased, were honored by medical auxiliaries all over the United States, and in some foreign countries. This particular day was selected because on this date in the 19th century, Georgia's own Dr. Crawford W. Long first used ether as an anesthetic.

The idea of Doctors' Day was the brain child of Mrs. G. B. Almond, of Winder, Georgia, in 1933. As a child, she had been comforted many times by her family physician. Later, she married a doctor. Mrs. Almond's suggestion, that a day be set aside to honor doctors, was adopted by the Medical Association of Georgia in 1934, and the following year by the American Medical Association. The official flower is the red carnation, and is given to each living doctor.

Griffin doctors were entertained March 29 at a dinner given by the Woman's Auxiliary of the Spalding Medical Society. Now none of us laymen could attend that dinner honoring doctors, but all of us could let our doctors know how much we appreciate them.

Griffin is especially fortunate in the high caliber doctors we have. General practitioners, surgeons, specialists in all lines, are among the some 30 physicians here.

Knowing many of them personally, Good Evening can truthfully say that we have as good doctors as any city in the state.

Hats off to our doctors!

Sometimes one hears someone indict all doctors as being "interested only in making money." And while that might be true with a very few of the doctors—just as it is true of a small section of lawyers, and even, possibly, some ministers—this blanket indictment is unfair.

For a great majority of our doctors are dedicated to their profession and work just as intelligently with charity patients as with the best paying ones.

Few people know the amount of work a doctor does for which he is not paid one cent. One day recently we ran a story telling about the City Commission approving a bill from the hospital for charity cases. This bill, for one month, was \$3,647.48.

When we read that story we wondered how much more it would have cost the city if it had been billed by the doctors for the free services they contributed to the needy. It is entirely possible that this bill, had such a one been sent, would have been several times more than the hospital bill.

"Well that's why my doctor charges me so much," one man said to Good Evening when we were discussing this. "He must charge me for the work he does free."

"High fees," we responded. "Of course they are higher than they were when you and I were younger. But everything has gone up—even your salary. You excuse the increases in your salary—(and we happened to know he makes twice as much as he did 15 years ago)—by saying it costs you more to live. Well it costs doctors more to live, too. And don't forget that doctors today are forced to have large office staffs of receptionists, secretaries, technicians, and nurses. Such a staff enables him to make a better diagnosis of what ails a patient."

And, as the unconvinced friend turned away, we were prepared to ask him how much he had spent in the past year in keeping his automobile in running shape and his TV set operating like he wanted it to work. But we did not have a chance.

No one would want an inexperienced, untrained mechanic repairing our car.

Certainly we should not want any but the best doctor when we need a physician.

Hats off to our fine doctors!

Griffin Daily News

J. M. A. GEORGIA



heart page

THE TREATMENT OF SHOCK COMPLICATING MYOCARDIAL INFARCTION

William Patrick Roche, Jr., M.D., *Dublin*

SHOCK OCCURRING DURING an acute myocardial infarction usually signifies extensive myocardial injury and, unless response to therapy occurs promptly, is an ominous prognostic sign. Varying degrees of hypotension may occasionally be present without development of clinical shock; however, this discussion is concerned primarily with those having the characteristic picture of cool, moist skin, a weak, rapid pulse, restlessness, pallor, and occasionally cyanosis. These symptoms usually are seen only when the systolic pressure drops below 80; occasionally they may occur at a higher blood pressure level in one who has pre-existing hypertension. An arrhythmia may occasionally be responsible for the picture of shock, but usually the symptoms are the result of a sudden reduction of the cardiac output due to myocardial injury. Hypotension and shock appear when the heart is thus unable to fill the existing vascular bed to capacity.

Prompt and vigorous therapy is urgent, as the prognosis becomes increasingly grave the longer the duration of shock. Milder cases may respond to simple measures such as elevation of the foot of the bed with eight to ten inch blocks, oxygen administration, and relief of pain. Narcotics should be used freely to control pain, restlessness, and dyspnea, but should be withheld in the absence of these symptoms since they tend to depress respiration and intensify

anoxia. Another contraindication to the above measures would be the use of the head-down position in the presence of pulmonary edema. In a situation requiring treatment of both shock and pulmonary edema, rapid digitalization by the slow intravenous administration of 1.2 to 1.6 mgm. Lanatoside C® or some similar, rapidly-acting digitalis preparation is indicated. Digitalis appears to have some beneficial effect on shock over and above that due to its ability to correct cardiac decompensation. There are some who advocate digitalization of everyone in shock, irrespective of the state of compensation. It is well to remember that Lanatoside C® is quickly excreted and that oral therapy using a longer acting cardiac glycoside is necessary if digitalization is to be continued. The initial oral dose may approach 50 per cent or more of the usual full digitalizing dose of the digitalis glycoside chosen, since so much of the Lanatoside C® will have been eliminated.

Arrhythmias, particularly ventricular tachycardia, may at time precipitate shock following an acute myocardial infarction. Recently, it has been shown that often correction of the hypotension alone results in disappearance of the arrhythmia. Thus one may be more justified initially in attempting to raise the blood pressure than in testing the effectiveness of various drugs on the arrhythmia.

If the simpler measures are ineffective, specific

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

vasopressor drugs are indicated. Levophed® is the most potent and perhaps most widely used vasopressor drug. One objection to its use is the intense local vasospasm and the occasional slough which results if the medication gets out of the vein and enters the adjacent tissue. Fortunately, subcutaneous infiltration of one to two cc. of Regitine® by multiple injections into the area of extravasation greatly reduces the vascular spasm, tissue injury and likelihood of developing a slough. The dose of Levophed® varies with the patient and with the degree of shock. The usual initial intravenous solution should contain one ampule (eight mgm. Levophed® bitartrate) in 1000 cc. of five per cent glucose in distilled water. Twenty to 40 drops of this solution per minute should be sufficient to maintain the blood pressure. If more than 40 drops per minute are required, the concentration of the solution should be increased by the further addition of one or two more ampules of Levophed®. This enables one to reduce the rate of administration and curtail the amount of intravenous fluid given.

The response to Levophed® is usually prompt, but great care must be exercised in regulating the rate of flow, since too slow an infusion may be ineffective while a rate that is too rapid may result in extreme hypertension. Initially, the blood pressure must be checked every one or two minutes and the rate adjusted until the desired blood pressure level is

reached. Thereafter, the blood pressure should be taken every 30 minutes to insure stability at the desired level. It is impossible in a given case to predict the length of time that an infusion of Levophed® must be continued. Only by periodically attempting to reduce or stop the infusion and determining the blood pressure for several hours thereafter, can one discover whether the circulatory system is able to maintain itself again without help. Not infrequently Levophed® may have to be continued for two or three days and occasionally for as long as a week. In addition to Levophed®, there are several other effective pressor amines including Aramine®, Wyamine®, and Vasoxyl®. While less potent, these have the advantage of requiring less meticulous supervision.

Other older methods of treatment of shock during acute infarction include intravenous administration of blood, saline, plasma or plasma expanders. These measures are not nearly as effective as is the use of pressor amines, and are potentially of great danger in that they may precipitate pulmonary edema. Because of this, their use should be discouraged. Finally, if all other measures fail, the use of intravenous Cortef® should be tried as an adjunct to the other therapy. Occasionally the addition of this medication will result in a change in the responsiveness to the pressor amines, presumably by correcting a temporary state of adrenal insufficiency brought on by prolonged shock. It is indeed rare, however, for a patient to survive who fails to respond to Levophed® alone.

A.M.A. COST OF MEDICAL CARE COMMISSION PROGRESS

THE AMERICAN MEDICAL ASSOCIATION'S Board of Trustees has established a Commission on the Cost of Medical Care.

This Commission will attempt to identify and assess the significance of the casual factors involved in determining the prices of and expenditures for individual components of medical care.

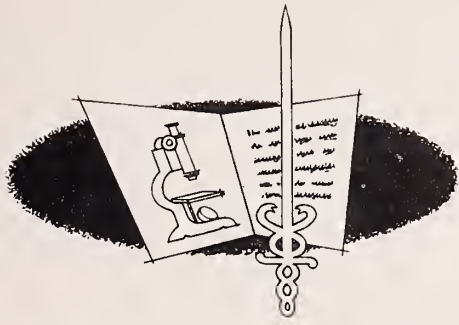
The Commission will: (1) review and evaluate pertinent studies completed or in progress; (2) suggest or initiate additional research studies on medical care costs and expenditures; (3) endeavor, on a continuing basis, to improve the understanding of physicians and individual citizens concerning the factors determining medical care prices and expenditures, and (4) report its findings and make appropriate recommendations. It is estimated that about three years will be required for the Commission to complete its work.

The Commission is headed by Louis M. Orr, M.D., Orlando, Fla., immediate past president of the A.M.A. He is ably assisted by David B. Allman, M.D., Atlantic City, N. J., also a past president of A.M.A. The director is Mr. C. Joseph Stetler, of Chicago.

The Commission consists of three committees: (1) Committee on Diagnosis, Therapy, and Clinical Management of Disease; (2) Committee on Financing Mechanisms, and (3) Committee on the Economics of Medical Care.

Each committee concerns itself with a particular segment of the overall study of the Commission, realizing, of course, that the work of each committee will, in some respects, parallel that of the other two.

The Commission would like to have any information—studies, publications, critiques, surveys, etc.—of the past five years which might be of value in this field.



cancer page

RADICAL HYSTERECTOMY

William J. Pendergrast, M.D., *Atlanta*

RADICAL HYSTERECTOMY AS conceived by Clark, Reis, Wertheim, and others was discarded because of excessive morbidity and mortality. In 1937, Fletcher Shaw, one of Britain's ablest surgeons, wrote "After careful observation of these cases for over seven years, Professor Douglas and I have come to the definite conclusion that radium offers the best chance of cure as well as being the more humane method of treatment. Therefore, strong advocates though we were of operation, we have now abandoned it."

In the early 1940's, however, there was a revival of interest in radical hysterectomy made possible by unusual advances in pre- and postoperative care. Meigs and others have shown that radical hysterectomy and pelvic lymph gland dissection, when done by an experienced team on carefully selected early cases, can offer results comparable to the best results of radiation therapy. The surgeon must be prepared to accept and manage the frequent complications of bladder atony, pyelonephritis with hydronephrosis and hydroureter, and urinary fistulae. Surgery cannot compete economically with radiation therapy. The total cost to the patient for x-ray and radium therapy is only about one-third to one-half the total cost of radical surgery. The number of hospital days required for radium therapy is also about

one-third those needed for radical surgery. Because of these reasons, we have limited the use of radical surgery for the following specific indications.

(1) *Young women below the age of 40 who have relatively early Stage I cancer of the cervix:* we try to leave an ovary whenever possible. This leaves the younger women with a softer more normal vagina. The trauma of an active sex life, we think, makes these patients more liable to necrosis in a heavily radiated cervix.

(2) *Residual or recurrent disease following radiation therapy:* about ten to 15 per cent of these patients will have residual cancer following radiation to the cervix. These cases must be treated surgically. The surgical complications are increased because of poor healing following heavy radiation, and ureteral stricture and necrosis is a frequent and serious problem.

(3) *Adenocarcinoma of the fundus with lymph node invasion:* although routine Wertheim hysterectomy has been advised for adenocarcinoma of the endometrium, we have not practiced this except in selected cases. Evidence of advanced disease with parametrial or lymph node invasion certainly warrants the more radical surgical approach.

(4) *Personal preference of the patient or physician:* most of the large series of cases treated by

Approved by Professional Education Committee, Georgia Division, ACS.

radical surgery have been done in teaching institutions as an experimental procedure. The general opinion still remains that radiation therapy is the treatment of choice in cancer of the cervix.

The more advanced cervical cancers in late Stage II and III require partial or total exenteration of the pelvis and surgical results are no better than the results following radiation. For this reason, exenteration procedures should be reserved for the patient with recurrent disease after radiation, or for the patient with invasion of the bladder or the rectum, or for massive radiation necrosis.

Although pelvic exenteration was begun as a palliative procedure, it has not proven to be palliative and should not be attempted unless a curative resection seems possible. Both Doctors Schmitz and Parsons have reported no five-year survivors in the cases who had positive lymph node metastases. The management of the urinary tract continues to be a major problem and this procedure should be carried out only after evaluation of the patient and careful explanation to her of the difficulties involved. The younger patient is more able to accept these problems, and we agree with others that patients beyond age 65 should not usually be subjected to this major surgical insult.

NEW YORK A GLAMOROUS SETTING FOR A.M.A. MEETING

SUMMERTIME IN NEW YORK CITY will provide a glamorous and exciting setting for the June 25-30 annual meeting of the American Medical Association.

Then, if ever, the fast pace of the city slows to permit the full enjoyment of its many virtues.

New York is "a nice place to visit." There's only one thing wrong with it. There's too much to do and see. The only way to really see the city is not try to see all of it.

Some of New York's best known attractions are located within a compact rectangle extending north from 34th Street to Central Park South and east from Broadway to Third Avenue. This area contains the fashionable shops of midtown Manhattan, the glamorous night clubs and restaurants, the Empire State Building and Rockefeller Plaza.



AMERICA'S FRONT DOOR—New York City—will present this glistering and glamorous facade of welcome to the nation's physicians, their families and their guests when the American Medical Association holds its 110th Annual Meeting there next June 25-30. More than 25,000 doctors are expected to attend the world's largest medical meeting and to enjoy the city's varied pleasures. Advance registration and hotel reservation forms appeared in J.A.M.A. (March 4, 18, April 1, 29, and May 13) and in April issues of all A.M.A. specialty journals.

It's fairly easy to get an overall look at the city. The view from the top of the Empire State Building remains one of the most spectacular. Another bird's eye view can be gained by taking a quickie helicopter flight over Manhattan.

The steamers that continually circle Manhattan via the East and Hudson rivers offer a different viewpoint. Departures are frequent and the trip takes about two and a half hours.

For a close-up of New York and New Yorkers, any city bus will take the tourist through interesting sections.

Regardless of how much time a visitor has for sight-seeing, he must take time to eat, and this can be one of the most enjoyable parts of a visit to New York.

New York, of course, is a center of jazz and name artists are presented at Eddie Condon's, Village Vanguard, Hickory House, Metropole, and The Embers.

The Broadway theaters alone offer a world of entertainment. Needless to say, tickets for hit shows are hard to get. Off-Broadway theaters, however, also offer good dramatic performances and tickets are not a problem.

Other points of interest include the United Nations and a long list of museums. For children there are the Hayden Planetarium, Coney Island, and the Bronx and Central Park zoos.

The museums and historic homes which should be mentioned are the Museum of Modern Art, Museum of Primitive Art, Whitney Museum of American Art, Frick Collection (paintings and sculpture), Guggenheim Museum, Museum of Natural History, Metropolitan Museum of Art, Museum of the City of New York, the Old Merchant's House, The Cooper Union Museum, Theodore Roosevelt Museum, Pierpont Morgan Library, and The Jumel Mansion.

There is much more to see and do in New York. But from what has been touched on here it should be clear why so many people find New York a wonderful—and varied place to visit.



legal page

SUBPOENAS

John L. Moore, Jr., *Atlanta*

PHYSICIANS ANNOYED BY frequent court appearances often ask lawyers about the circumstances under which they must appear in response to a subpoena. A review of pertinent statutory provisions as to appearances in the State and Federal courts might be helpful in this column.

The first and very important rule is that any person should punctiliously obey any court process unless carefully advised to the contrary. Any physician who relies on the general statement in an article such as this to refuse to appear in response to a subpoena without expert and individual legal advice may find himself in prison for 20 days for contempt.

A subpoena to any witness (including expert witnesses) to appear and testify in court must be personally served on the witness at least one day before the trial of the cause. The subpoena must be signed by the Clerk of the Court, but he may sign subpoenas in blank and deliver them to the attorney who must fill in the name of the witness before service. The subpoena duces tecum (to produce a document, deed, or writing) must be served ten days before the hearing if in the Superior Court or five days in a Justice Court. The person receiving a subpoena duces tecum may relieve himself of the obligation to appear by filing the document named in the subpoena with the party or the attorney issuing the subpoena or in the office of the court from which the subpoena issued. In the case of either kind of subpoena, a failure to obey may subject the witness to bodily attachment by the officers of the

court, to a fine not exceeding \$300, and imprisonment not exceeding 20 days. Witnesses in a State court held in the county in which the witness lives are entitled to a per diem of 75¢ for each day actually spent in court. However, under Georgia procedure the payment of the witness fee may not be demanded as a condition precedent to attendance at court. A subpoena to a Georgia State court may not be dishonored because there is no tender of the per diem. If the trial is being held in a court of a county in which the witness does not reside, the witness must be tendered at the time of the service of the subpoena a per diem of \$7.00 and mileage of \$0.07 per mile to attend the place of the trial. However, subpoenas requiring attendance at a court more than 100 miles by the nearest practical route are not proper. Subpoenas for deposition (testimony prior to trial) are generally governed by the same rules except that the deposition should be held in the county in which the deponent or witness resides.

In Federal courts provisions are similar except that the per diem for all witnesses is \$4.00 and the mileage is at the rate of \$0.08 per mile. One decision held that the subpoena to appear in Federal court was not enforceable because there was insufficient tender of the per diem and mileage at the time of the service of the subpoena, but some decisions indicate that if a witness can pay his own expenses and refuses to attend because the per diem and mileage are not tendered him at the service of the subpoena, he may be punished for contempt. Consequently, a Federal subpoena should be treated like a subpoena

Prepared at the request of the Medical Association of Georgia. Mr. Moore is an associate in the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.

to appear in a court of the State of Georgia.

Both State and Federal courts require that the witness appear even though he may think that his testimony has no relevance to the cause of action. In the Federal courts a procedure is established for making a motion to quash the service of the subpoena prior to appearance, but a witness, even though he is correct in thinking so, may be punished for contempt for refusing to appear because he thinks his evidence is irrelevant or inadmissible in the particular case.

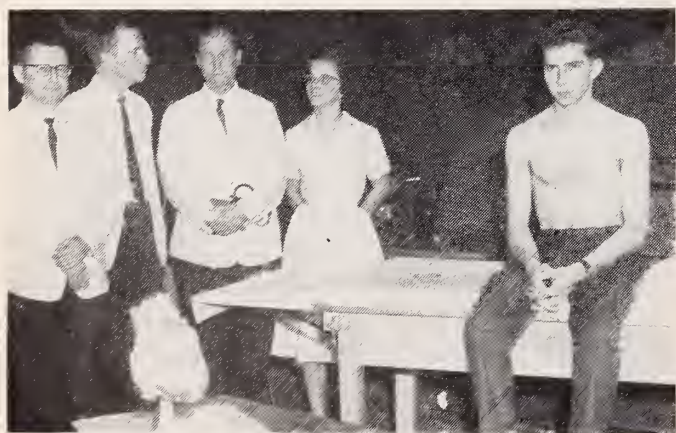
An interesting Georgia case deals with a physician who was subpoenaed to serve as an expert witness. The Court of Appeals of Georgia held that no statute in Georgia allows or prohibits fees to expert witnesses. Therefore, the expert witness subpoenaed to appear in court may make no charge beyond the legal fee of a witness for appearing in court in obedience to the subpoena. However, the court went on

to say that the expert witness could demand extra compensation for the other necessary services, that is, for the examination or preliminary preparations and for listening to the testimony. Thus, once a physician has become involved in a case to the extent of examining a party he cannot refuse to obey a subpoena because he has not already been paid his compensation for extra services. His only recourse is to normal methods of collection of any professional fee.

The reader's attention is called to the Interprofessional Code adopted by The Medical Association of Georgia and the Georgia Bar Association in 1957, and distributed to all members of MAG in the March issue of the *Journal*. The Code, especially Section D, spells out means whereby the subpoenaed physician can be treated courteously and with the greatest consideration for his time. It is to be hoped that cooperation between the professions will result in Georgia in a state of affairs where the physician no longer dreads the service of a subpoena.

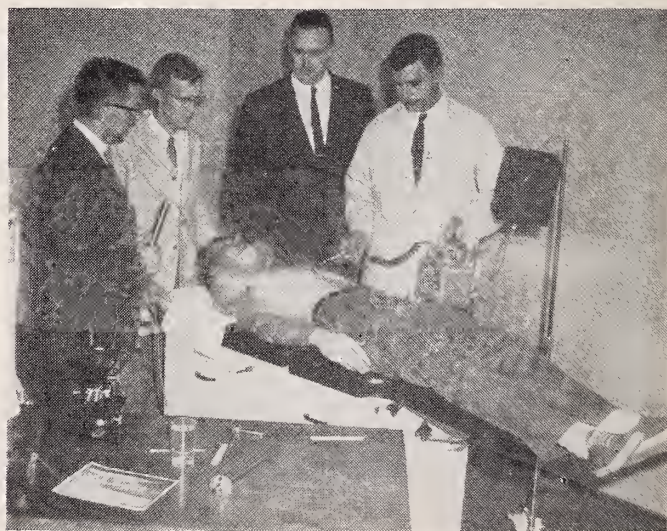
WALB-TV PRESENTING SERIES OF MEDICAL DOCUMENTARIES

ON FEBRUARY 22ND, WALB-TV presented its first documentary entitled "The Human Heart." This program has received wide public acclaim from viewers in South Georgia and North Florida. On Wednesday, March 29th, at 10:30 P.M., Channel 10 again presented a program of this scope. With the cooperation of the American Cancer Society, the Dougherty County Unit of the American Cancer Society, and the Dougherty

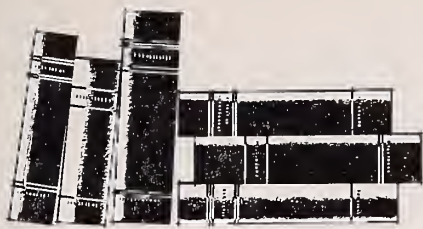


"THE HUMAN HEART"—WALB-TV's documentary "The Human Heart" that was presented live Wednesday night, February 22, 1961, has received public acclaim from viewers in Georgia and Florida. The sponsor of the program, Midtown Drugs, in Albany, was so impressed, he expressed desires to sponsor future programs of this scope. Participating physicians on the program were Dr. Thomas D. Johnson, Dr. Charles C. Lamb, and Dr. Charles S. McCall, Jr., all of Albany.

County Medical Society, Channel 10 explored "Cancer." The program consisted of live demonstrations of how and why radioactive isotopes and radium are used to treat cancer. Various types of equipment used for the treatment of cancer were shown.



"CANCER"—The public called it excellent, educational, informative . . . this was said by the people in South Georgia and North Florida concerning WALB-TV's documentary "Cancer" that was presented "live" Wednesday night, March 29, 1961, on Channel 10 in Albany, Georgia. Participating physicians were Dr. T. Gray Fountain, Dr. O. Grey Rawls, and Dr. W. Frank McKemie, all of Albany. The program was produced by WALB-TV's Public Affairs Department, through the cooperation of the American Cancer Society.



physician's bookshelf

BOOKS RECEIVED

Reynolds, Fred C., M.D., **INSTRUCTIONAL COURSE LECTURES**, Vol. 17, The C. V. Mosby Co., St. Louis, Mo., 1960, 421 pp., \$18.50.

Carter, Richard, **THE GENTLE LEGIONS**, Doubleday & Co., Inc., Garden City, N. Y., 335 pp., \$4.50.

Meyer-Schwickerath, Gerd, M.D., **LIGHT COAGULATION**, The C. V. Mosby Co., St. Louis, Mo., 1960, 114 pp., \$9.50.

Slaughter, Frank G., **EPIDEMIC!**, Doubleday & Co., Inc., Garden City, N. Y., 1961, 286 pp., \$3.95.

Wolstenholme, G. E. W., O.B.E. and O'Connor, Maeve, B.A., **CIBA FOUNDATION SYMPOSIUM ON HAEMOPOIESIS**, Little, Brown and Co., Boston, Mass., 1960, 490 pp., \$11.00.

Kroger, William S., M.D., **CHILDBIRTH WITH HYPNOSIS**, Doubleday & Company, Inc., Garden City, N. Y., 1961, 216 pp., \$3.95.

Hutton, Isabel Emslie, M.D., **THE SEX TECHNIQUE IN MARRIAGE**, Emerson Books, Inc., New York, N. Y., 1961, 191 pp., \$3.00.

Dubos, Rene, **MIRAGE OF HEALTH**, Doubleday & Company, Inc., Garden City, N. Y., 1961, 235 pp., \$95.

Stanley-Jones, D. and K., **THE KYBERNETICS OF NATURAL SYSTEMS**, Pergamon Press, New York, N. Y., 1960, 145 pp., \$6.50.

Goldman, Robert P., **LOSE WEIGHT AND LIVE**, Doubleday & Company, Inc., Garden City, N. Y., 1961, 235 pp., \$3.95.

Nagan, Peter S., **MEDICAL ALMANAC 1961-62**, W. B. Saunders Co., Philadelphia, Pa., 1961, 528 pp., \$5.00.

Willson, J. Robert, M.D., **ATLAS OF OBSTETRIC TECHNIC**, The C. V. Mosby Co., St. Louis, Mo., 1961, 304 pp., \$14.50 (de luxe) and \$12.50 (regular).

Conn, Howard F., M.D., **CURRENT THERAPY—1961**, W. B. Saunders Co., Philadelphia, Pa., 1961, 806 pp., \$12.50.

Conwell, H. Earle, M.D. and Reynolds, Fred C., M.D., **KEY AND CONWELL'S MANAGEMENT OF FRACTURES, DISLOCATIONS, AND SPRAINS**, The C. V. Mosby Co., St. Louis, Mo., 1961, 1153 pp., \$27.00.

REVIEWS

Williamson, Paul, M.D., **OFFICE DIAGNOSIS**, W. B. Saunders Co., Philadelphia, Pa., 1960, 470 pp., \$12.50.

IN THE PREFACE the author states that his book is not

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

a compendium of diagnostic techniques and maneuvers but a series of articles designed to help the practitioner. The book is divided into 12 sections according to anatomy and systems, and includes 99 chapters. Very rare conditions and diseases that are not usually diagnosed either have been passed over entirely or mentioned only. The author states, "This book can only represent what I think and what I do. It must, by the very nature of the subject, evoke strong disagreement."

I think the author accomplishes his objectives. I certainly disagree with him about ten per cent of the time. The first chapter on the art of diagnosis is good. Here the author emphasizes the need of a thorough searching history in order that the doctor can understand the patient's real feelings, thoughts, and actions. The first section on non-specific symptoms is well done. Chapter 14 on the ambulatory psychotic is especially good.

Although the author is well versed in electrocardiography, the illustrations in this field are frequently not too good. I think they will tend to confuse the practitioners who are not well versed in electrocardiography. I also feel that the discussion and illustrations on fluoroscopy and chest radiography will be confusing, as these illustrations frequently are not of good quality.

On page 211, one illustration of the esophagus in the right anterior oblique position seems to be left out entirely. The illustration that is present purports to show a patient being x-rayed in the right anterior oblique position really shows a patient in the left anterior oblique position. On page 212, is a phonocardiogram supposed to show aortic insufficiency, but really illustrating aortic stenosis. On page 340, there is an illustration showing a rectal examination being performed with an ungloved hand. I doubt if this suggestion will be followed by many of the readers.

After reading the volume, one gains the impression that the author is certainly a wise and astute clinician. In his next revision, the section on heart murmurs should include aortic stenosis and something on the congenital hearts. The section on hypertension should at least mention the curable forms of hypertension.

W. Granville Tabb, Jr., M.D.

Page, Ernest W., M.D. and Stevenson, Charles S., M.D., **CLINICAL OBSTETRICS AND GYNECOLOGY**, Vol. 3, No. 2, Paul B. Hoeber, Inc., New York, N. Y., June, 1960, 261 pp., pub. quarterly, \$18.00 per year.

THIS BOOK IS THE June 1960 issue of a quarterly publi-

PHYSICIAN'S BOOKSHELF / Continued

cation dealing with clinical obstetrics and gynecology. The obstetrical part of the book is titled "Physiology of Pregnancy" and is edited by Dr. Ernest W. Page. The gynecological portion is titled "Endometriosis" and is edited by Dr. Charles S. Stevenson.

There are ten chapters devoted to the physiology of pregnancy and each is authored by an authority in the subject matter. As examples, Dr. Page writes on the physiology of the human placenta at term; Dr. Harry Prystowsky writes on fetomaternal gas exchange, and Drs. Caldeyro-Barcia and Porserio write on the physiology of uterine contraction. This part of the book is superb and fills a definite need. From this the clinician can catch up on much of the latest developments in the physiologic research in his specialty and where possible, the clinical implications are pointed out and discussed.

The last part of the book is a good review of endometriosis and contains seven chapters written by well known contributors. All the different aspects of endometriosis, from mechanisms of origin and pathology to surgical and medical treatment of the disease are covered. In the last chapter, Dr. Stevenson presents some of his ideas and questions concerning this condition and illustrates some of the unusual problems with case reports.

Mark Pentecost, Jr., M.D.

Ritchie, Douglas, STROKE, Doubleday & Co., Inc., Garden City, N. Y., 1961, 192 pp., \$3.50.

"STROKE" IS AN ACCOUNT of the thoughts of a man of age 50 years who had a right hemiplegia with aphasia. The book gives in minute details his experiences and reactions to his disease and those people in his life, his family, and the physicians, physiotherapists, and others. The duration of the diary is of three years happenings leading to eventual recovery of sufficient degree by the patient so that he could handle himself alone and think clearly and write despite considerable effort.

This book may aid some patients with stroke and their families, but contrarily it may be quite depressing to some. It would seem unnecessary to the many people who have mild strokes with rather rapid recovery, although it might give courage to those with severe stroke or those in contact with such patients during their long and tedious rehabilitation.

The reviewer does not think it can be recommended without selection to all stroke patients.

T. Sterling Claiborne, M.D.

Eysenck, H. J., Ph.D., BEHAVIOUR THERAPY AND THE NEUROSES, Pergamon Press, New York, N. Y., 1960, 479 pp., \$10.00.

THE BOOK IS DIVIDED into five sections: (1) Theoretical Bases and Classical Experiments, (2) Reciprocal Inhibition Therapy, (3) Therapy by Negative Practice and Conditional Inhibition, (4) Aversion Therapy, and (5) Therapy by Positive Conditioning and Feedback Control. The editor has written a foreword and an introduction to each of the sections and a final conclusion. The material consists of 36 papers by the editor and others dating from 1926 and for the most part published else-

where. A few of the papers were written specifically for this volume. Except for section 1, the remainder of the papers are case reports, illustrating methods of treatment based on learning theory and various adjunctive measures.

The editor differentiates behavior therapy from psychoanalytic therapy by the characteristic that in the former the removal of symptoms is the main objective, while in the latter the correction on the underlying cause is the prime objective. His concept of a neurosis is that the symptoms are the neurosis and are learned reactions which must obey the laws of learning. He maintains that elimination of the symptoms eliminates the neurosis, different from the psychoanalytic idea that the neurosis must be cured before the symptoms leave. The writers frequently call attention to patients in whom a removal of a symptom did not result in the formation of a new symptom, as intimated by the psychoanalytic school. The editor maintains that psychotherapy must follow the principles of learning theory in order to be successful.

The article of Liversedge and Sylvester on writer's cramp and that of Wolpe on treatment by reciprocal inhibition are most informative.

The writers analyze the patients according to learning theory, then construct a treatment plan, including the devising of equipment, based on the theory, and give a running account of the procedure.

This book traces the development of behaviorism and learning theory from Watson until the present by the use of the publications of the various investigators in the field.

The editor's purpose was so close the gap between academic psychologists and applied psychologists. This collection of papers will be of interest to psychologists and psychiatrists concerned with investigating methods of treatment of psychologic disorders.

Joseph S. Skobba, M.D.

Artz, Curtis P., M.D., F.A.C.S. and Hardy, James D., M.D., F.A.C.S., COMPLICATIONS IN SURGERY AND THEIR MANAGEMENT, W. B. Saunders Co., Philadelphia, Pa., 1960, 1,075 pp., \$23.00.

"COMPLICATIONS IN SURGERY AND Their Management" is a 1,000-page atlas of the experience of renowned authorities in each of the fields covered. The book has 59 chapters with subject matter which varies from infections in surgery to cardiovascular and pediatric surgery. Stress is placed on factors which predispose to development of complications and the treatment subsequent to their occurrence. Warnings against the common complications and suggested preventive measures are recorded. Should complications arise the methods used by prominent authorities in each field is discussed in distinct easily readable form.

The subject matter is divided so that the common operative procedures can be located in the table of contents and information regarding the possible complications and treatment thereof readily found. The book is unique in that it is a single volume where a complete dissertation of complications is recorded. It is recommended to both the accomplished surgeon, the resident, and the student as a valuable source to assist in the preoperative, operative, and postoperative care of surgical patients.

J. A. Thompson, M.D.

J. M. A. GEORGIA



current clinical concepts

Effect of Maternal Ingestion of Iophenoxic Acid

IT HAS BEEN demonstrated that iophenoxic acid (Teridax®) which is used as a cholecystographic medium can cross the placental barrier into the fetal blood stream many years after the ingestion by the mother and cause persistent elevated concentration of protein-bound iodine in both the mother and the children. The use of the compound should be discontinued, the authors state.

Shapiro, Robert, M.D.: The Effect of Maternal Ingestion of Iophenoxic Acid on the serum Protein-Bound Iodine of the Progeny, *N. Eng. J. Med.* 264, Feb. 23, 1961.

Unsuspected Carcinoma in Surgical Specimens of the Prostate

CARCINOMA OF THE prostate is found in approximately one in 13 patients who undergo prostatectomy for benign prostatic hypertrophy. The mortality in the unsuspected prostatic carcinoma group is not greater than the anticipated mortality for the age group, and is less than one-half that of those patients having clinically suspected carcinoma of the prostate.

Joslin, Albert H.; Lich, Robert, Jr., and Barnes, Malcolm L.: Unsuspected Carcinoma in Surgical Specimens of the Prostate, *S. Med. J.* 54, March, 1961.

Office Management of Varicose Veins

IN OFFICE MANAGEMENT of varicose veins, a 50 per cent dextrose solution, 10 or 20 per cent sodium chloride solution, or a mixture containing 10 per cent sodium chloride and 30 per cent invert sugar can be used for obliteration of varicose veins. Any of these are excellent sclerosing agents and do not

elicit adverse reactions; such as, urticaria, angioneurotic edema, and shock.

JAMA Question & Answer Section, Oct. 1960.

Celiac Disease

CORRECTION OF THE histologic abnormalities in the duodenal mucosa of children with celiac disease by treatment with a gluten-free diet suggests a relation between the anatomic lesions and the ingestion of wheat gluten.

Anderson, C. M.: Mucosal Changes in Celiac Disease, *Arch. Dis. Child.* 35:419, 1960.

Sciatic Palsy

THE AUTHORS, REVIEW observation on 21 pediatric patients in whom sciatic palsy was associated with intragluteal injections. It is suggested that the buttock be abandoned as a site of injection in infants and children and the lateral distal third of the thigh is recommended as a preferable injection site.

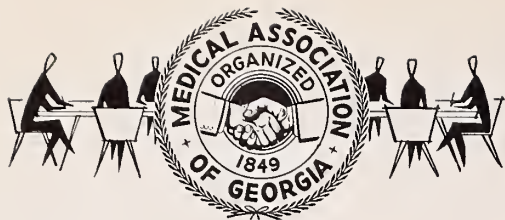
Gilles, F. H. and French, J. H.: Postinjection Sciatic Nerve Palsies in Infants and Children, *J. Ped.* 58:195, 1961.

Rapid Diagnosis of Diphtheria

DIFFERENTIATION OF TOXIGENIC from nontoxigenic *C. diphtheriae* on direct throat swabs is possible by using the fluorescein-conjugated diphtheria antitoxin test.

The test can be performed in less than an hour and appears to be a valuable adjunctive test for the rapid diagnosis of diphtheria.

Whitaker, J.; Nelson, J. D., and Fink, C. W.: Fluorescent Antitoxin Test for Immediate Diagnosis of Diphtheria, *Ped.* 27:214, 1961.



the association

DEATHS

J. C. COLLINS, 85, of Collins, died suddenly at his home March 10.

A native of Tattnall County, Dr. Collins had been practicing medicine in Collins and the surrounding communities for nearly 60 years.

Although he had suffered a heart attack about a year ago, he recovered quickly and had been active in practice recently.

Dr. Collins graduated from the Medical College of Georgia in 1901. He had practiced in several other places including Cedar Crossing, Uvalda, and Claxton, before locating in Collins in the 1920's. He also ran a farm near Collins.

He was honored at a "Dr. Collins Appreciation Day" on his birthday several years ago at the Collins Baptist Church, where he was a deacon.

Dr. Collins had served as mayor of Collins for several terms, had been on the Collins School Board of Trustees, and was a member of the Tattnall County Medical Society, the Medical Association of Georgia, and the American Medical Association. He was a surgeon for the Seaboard Air Line Railway and a member of Ezell Lodge 335, F. & A.M.

Survivors are two sons, J. C. Collins, Jr., Claxton and Edgar Collins, Hinesville; four brothers, Perry B. Collins, Twin City, Edmund Collins, Bartow, Fla., G. Wright Collins, Collins, and Brewton Collins, Claxton; two sisters, Mrs. Emma Harrison, Brooklet and Mrs. Pearl Lipford, Americus; four grandchildren, and three great-grandchildren.

WALTER FAUST DURDEN, of Gainesville, died suddenly March 9 at the age of 36.

Dr. Durden, a native of Monroe, attended North Georgia College, the University of Georgia, and the Medical College of Georgia. His internship and residency was served at Grady Memorial Hospital in Atlanta.

He was a member of the First Baptist Church, a veteran of three years in the medical corps, including service in the Korean conflict, a member of the Chattahoochee Country Club, Elks Lodge, American Legion,

Hall County Medical Society, and the American College of Surgeons.

He is survived by his wife, Mrs. Louise Sims Durden and a son and daughter, Walter Faust Durden, Jr. and Melissa Durden, all of Gainesville; his mother, Mrs. John G. Durden, Monroe, and a brother, Dr. John G. Durden, Jr., of Columbus.

EDWIN N. MANER, retired ear-eye-nose-and-throat specialist in Savannah, died March 23 in a hospital in Savannah at the age of 67.

At the time he was stricken ill, Dr. Maner was actively engaged in practice. In addition to his private practice, Dr. Maner devoted much time to public health work and in the middle 1930's was president of the Savannah Health Center. In 1949 he was president of the Georgia Society of Ophthalmology and Otolaryngology.

For some years Dr. Maner was an active member of the Savannah Kiwanis Club and at the time of his death was an honorary member of the organization. He was a member of the Independent Presbyterian Church and Landrum Lodge No. 40, F. & A.M.

A veteran of World War I, he served in the medical corps in the European Theater and was wounded in the battle of the Argonne Forest.

Survivors include his wife, Mrs. Margaret Debele Maner; two sons, Edwin N. Maner, Jr., Savannah and Dr. F. Debele Maner, Decatur; a daughter, Mrs. Cecil Gnann, St. Simons Island; a sister, Mrs. Kenneth Powell, Augusta; a brother, William A. Maner, Jr., Augusta, and several grandchildren.

SOCIETIES

The CAMDEN-CHARLTON MEDICAL SOCIETY has recently been granted a charter by the Medical Association of Georgia. Members of the Society are: J. O. Simmons, Woodbine; G. W. Barker and Rex Stubbs.

St. Marys; R. R. McCollum and H. H. Robinson, Kingsland, and J. Jackson, C. H. Harvey, and E. C. Lundell, Folkston.

A. J. Aselmeyer, Director, Division of Tuberculosis Control of the State Health Department, spoke on "Tuberculosis Control in Georgia" at the March meeting of the CARROLL-DOUGLAS-HARALSON MEDICAL SOCIETY.

The Colquitt County Medical Auxiliary honored the members of the COLQUITT COUNTY MEDICAL SOCIETY at a dinner party given at the Elk's Lodge in Moultrie recently in the observance of Doctors' Day.

Recently, the COWETA COUNTY MEDICAL SOCIETY met at the Ranch House Motel and Restaurant in Newnan. J. H. Arnold and Ernest E. Proctor presented a case of proved trichinosis observed in the Newnan Hospital.

Members of the DOUGHERTY COUNTY MEDICAL SOCIETY paid tribute to two Albany physicians, W. S. Cook and J. A. Redfearn, and presented them with plaques commemorating their combined medical services of more than 100 years during the March meeting of the Society.

The Rome Shrine Club held its annual dinner meeting recently at the Greystone Hotel, hosting members of the FLOYD COUNTY MEDICAL SOCIETY. Osler Abbott and Edgar F. Fincher, both of Atlanta, were the guest speakers.

The members of the FULTON COUNTY MEDICAL SOCIETY were honored at a dinner dance recently at the Standard Club, when members of the Auxiliary to the Fulton County Medical Society paid Doctor's Day honors to their husbands.

The regular meeting of the GEORGIA MEDICAL SOCIETY was held in April. James A. Kemp, Medical College of Georgia, spoke to the group on "Auto-immune Diseases."

At a recent meeting of the GLYNN COUNTY MEDICAL SOCIETY, held at Crews Restaurant, a very interesting talk on surgery of the head and neck was given.

An interesting program was presented by the County Welfare Director at a recent meeting of the JEFFERSON COUNTY MEDICAL SOCIETY held at the Jefferson Hotel in Louisville.

Members of the Richmond County Medical Auxiliary recently honored the members of the RICHMOND COUNTY MEDICAL SOCIETY at a Doctor's Day Dinner held at the Elks' Club in Augusta.

The SOUTHWEST GEORGIA MEDICAL SOCIETY and the Auxiliary held their regular bi-monthly meeting at the Woman's Club in Blakely in March with Dr. and Mrs. Jack G. Standifer as hosts.

Members of the SPALDING COUNTY MEDICAL SOCIETY were guests at the Woman's Auxiliary at a dinner held at the Elks Club in Griffin in observance of Doctor's Day.

"South of the Border" was the theme of the dinner at the Americus Country Club given by the Woman's Auxiliary honoring members of the SUMTER COUNTY MEDICAL SOCIETY commemorating Doctor's Day.

The first quarterly meeting of the THOMAS-BROOKS MEDICAL SOCIETY was held in March at the Quitman Country Club. The guest speaker was Dr. Gerold Schiebler, of the Florida Medical School in

Gainesville, who spoke on "Surgery in Pediatric Cardiology."

Doctors of the WARE COUNTY MEDICAL SOCIETY were honored recently at a supper and square dance at the Okefenokee Golf Club given by the Woman's Auxiliary.

The annual meeting of the FIRST DISTRICT MEDICAL SOCIETY was held April 12 at the Forest Heights Country Club in Statesboro, with William H. Fulmer presiding and Albert M. Deal, Chairman.

The semi-annual meeting of the SECOND DISTRICT MEDICAL SOCIETY was held April 6 at the Blakely Town and Country Club. "Pelvic Pain in Women" was presented by Frederick P. Zuspan, Professor and Chairman, Department of Obstetrics and Gynecology, Medical College of Georgia, Augusta, and "Common and Uncommon Ear Problems" was presented by James T. Flynn, Jr., Moultrie.

PERSONALS

First District

WILLIAM G. SIMMONS, Sylvania, has completed his annual two weeks of active duty at the Hunter Air Force Base in Savannah. Dr. Simmons was also recently chosen "Rotary Man of the Year" at the annual Ladies Night Banquet of the Sylvania Rotary Club.

Air National Guard officials at Travis Field announced recently the appointment of HARRY E. ROLLINGS, Savannah, as a lieutenant colonel in the Georgia Air National Guard and the USAF Reserve.

DR. and MRS. CURTIS G. HAMES, Claxton, have returned from New York City where Dr. Hames attended the American College of Physician's course, "Recent Advances in Cardiovascular Disease."

L. H. GRIFFIN, Claxton and A. J. YATES, Soper-ton, recently attended a postgraduate course in gynecology at the Medical College of Georgia in Augusta.

HOWARD MORRISON, Savannah, recently spoke to the Thunderbolt School PTA on advances in child care during the last 50 years.

LAMONT DANZIG, Savannah, recently spoke in Statesboro before the regular meeting of the Tri-County Medical Society on the subject of the artificial kidney in the treatment of acute renal shutdown.

CHARLES USHER, JR., Savannah, recently attended a symposium on the biology and treatment of intracranial tumors, which was sponsored by the Houston Neurological Society and the Department of Neurology at Baylor University College of Medicine.

Second District

No news submitted.

Third District

JAMES W. WARD, Columbus, recently announced the removal of his office to the Doctor's Building, Room 110, in Columbus.

Some 6,500 people in Marion County relaxed for the first time in almost three months as a young physician,

W. McCALL CALHOUN, began general practice in the Buena Vista Infirmary.

LIONEL M. YOE, Columbus, recently announced the removal of his offices to Suite 109, Doctors Building, Columbus.

The meeting of the Muscogee Chapter, American Business Women's Association, was held recently with SIMONE BROCATO, Columbus, as guest speaker; his topic was "Heart Diseases."

Fourth District

At a recent meeting of the LaGrange Junior Chamber of Commerce, H. H. HAMMETT, JR., LaGrange, spoke on "To Smoke or Not to Smoke."

ULRICH H. HARTE, Newnan, has recently been elected as a member of the American Society of Abdominal Surgeons.

EDWARD A. PRIETO, formerly of Adairsville, recently opened his offices in Pine Mountain.

Fifth District

C. C. AVEN, Marietta, was recently the principal speaker at the annual meeting of the Colquitt County Tuberculosis Association.

R. BRUCE LOGUE, Atlanta, has been elected president of the Emory University Medical Alumni Association. F. WILLIAM DOWDA, Atlanta, was elected secretary-treasurer and A. EUGENE HAUCK, Atlanta, was elected as a trustee.

At a recent forum on cancer held at the Lawrenceville Elementary School, ROBERT L. BROWN, Atlanta, was a panel member.

What the high school student wants most to know about the medical problems life offers was disclosed recently when members of the Delta Club of North Fulton High School and some invited friends had a panel of Fulton County medical authorities discuss such problems. The group was composed of E. NAPIER BURSON, JR., chairman; JOHN M. BREWER; R. J. VAN DE WETERING; WOOD LOVELL, and JOHN R. LEWIS, all of Atlanta.

WALTER L. BLOOM, Atlanta, was recently guest speaker in the section on Internal Medicine at the 24th annual meeting of the New Orleans Graduate Medical Assembly at the Roosevelt Hotel, New Orleans.

TED F. LEIGH, Atlanta, was recently guest speaker at the meeting of the Detroit Roentgen Society in Detroit, Michigan.

J. FRANK WALKER, Atlanta, spoke recently to the North Fulton Optimist Club on "Health Care of the Aging."

Sixth District

BEN C. BARROW, Monticello, recently attended a postgraduate course on gynecology at the Medical College of Georgia in Augusta.

The Management of patients with vascular disease was the subject of a postgraduate course held recently at the Medical College of Georgia in Augusta and was

attended by CHARLES B. FULGHUM, Milledgeville and E. A. HENSLEY, Gibson.

Seventh District

D. LLOYD WOOD, Dalton, recently attended a postgraduate course in gynecology at the Medical College of Georgia in Augusta.

Eighth District

A Berrien County native, Y. F. CARTER, Nashville, has been named by Gov. Ernest Vandiver to fill a position on the State Board of Medical Examiners.

HENRY T. SHERMAN, Valdosta, was guest speaker at a recent meeting of the Pilot Club in Moultrie.

CLYDE V. TANNER, formerly of Dalton, has returned to his native Douglas to practice medicine.

Ninth District

At a recent forum on cancer held at the Lawrenceville Elementary School, D. C. KELLEY, Lawrenceville, was a panel member.

A. A. ROGERS, SR., of Commerce, recently retired from 40 years of practicing medicine in Commerce and Jackson County.

Tenth District

The Lavonia High School football team of 1960 recently honored J. WELDON WILLIAMS, JR., of Lavonia, "for loyalty and contributions to the team."

An Augustan, DAVID R. THOMAS, was recently elected a member of the Board of Regents of the American College of Allergists in a session held at Dallas, Texas.

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MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING

THE MEETING OF THE Council of the Medical Association of Georgia was called to order by the Chairman J. G. McDaniel at 2:00 P.M., March 25, 1961, at the MAG Headquarters Building, Atlanta, Georgia.

The invocation was given by Dr. Goodwin.

Council members present, in addition to Chairman McDaniel, were: Milford B. Hatcher, Macon, President; Fred H. Simon-ton, Chickamauga, President-Elect; Luther H. Wolff, Columbus, Immediate Past President; Braswell E. Collins, Macon, Second Vice President; John T. Mauldin, Atlanta, Secretary; C. Raymond Arp, Atlanta, Treasurer; Thomas W. Goodwin, Augusta, Speaker of the House; J. Frank Walker, Atlanta, Vice Speaker of the House; George R. Dillinger, Thomasville, Second District; W. G. Elliott, Cuthbert, Third District; Virgil B. Williams, Griffin, Fourth District; George H. Alexander, Forsyth, Sixth District; Ralph W. Fowler, Marietta, Seventh District; F. G. Eldridge, Valdosta, Eighth District; C. R. Andrews, Canton, Ninth District; Addison W. Simpson, Washington, Tenth District; T. A. Peterson, Savannah, First District Vice Councilor; Charles S. Jones, Atlanta, Fifth District Vice Councilor; Paul T. Scoggins, Commerce, Ninth District Vice Councilor; AMA Delegates J. W. Chambers, LaGrange; Eustace A. Allen, Atlanta, and Henry H. Tift, Macon. Also in attendance were: Edgar Woody, Jr., Atlanta, Editor, JMag; David R. Thomas, Augusta, Chairman, Insurance and Economics Committee; John S. Atwater, Atlanta; James W. Smith, Manchester; Jack W. Whitworth, Greenville; Dr. W. E. Coleman, President-Elect of the Georgia Dental Association; Dr. W. J. Meadors and Dr. E. Dalton McGlamery, Georgia Podiatry Association; Mr. Francis Shackelford and Mr. John Moore, MAG Attorneys; Mr. Richard Nelson, AMA Field Representative; Mr. Milton D. Krueger, Executive Secretary, and Mrs. Catherine Wooten, Executive Assistant.

Chairman McDaniel called on Mr. Krueger to read the minutes of the Council meeting of December 11, 1960, and the Executive Committee of December 11, 1960, January 22, 1961, and February 19, 1961. There being no corrections, on motion duly made and seconded, the minutes were then approved.

Dr. McDaniel then introduced Mr. Richard Nelson, AMA Field Representative to the Council.

Georgia Podiatry Association

Dr. W. J. Meadors, President of the Georgia Podiatry Association, made a request that the Blue Shield Act be amended to allow podiatry fees to be included in the allowances. The podiatrists are particularly interested in the Atlanta and Savannah Plans. He stated that this cannot be done without the approval of the Medical Association of Georgia. He made two requests: (1) that MAG assist the Georgia Podiatry Association in changing the Act; (2) approve negotiations between the Podiatry Association and the Atlanta and Savannah Plans. Dr. McGlamery, Secretary of the Podiatry Association, added a few words to emphasize the requests. After general discussion and on motion (Hatcher-Alexander) it was voted that the Chairman appoint a committee to study this matter, with the MAG attorneys, and report to Council.

Crawford W. Long Memorial Appropriation

Paul T. Scoggins gave this report. On motion duly made and seconded it was voted to allow Dr. Scoggins to regulate the amount and bring the matter before the House of Delegates.

MAG Legislative Report

(a) *Breakfast Meeting*: Dr. Mauldin gave a report on this meeting to Council. It was suggested that other such meetings with large organizations be held.

(b) *Washington Russell Trip*: Report received for information.

(c) *Washington Legislative Dinner*: This is being planned by Legislative Committee.

(d) *Georgia Legislature Report*: Received for information.

(e) *AMA Legislative Conference and Plan of MAG Action*: President Hatcher reported on the AMA Conference held in Chicago recently. He then asked Council to approve a "Special Called Meeting" in Macon, April 23, 1961, to bring the information received in Chicago to the entire MAG membership. On motion (Jones-Elliott) it was voted to hold the meeting. On motion (Mauldin-Wolff) it was voted to invite the Auxiliary, dentists, pharmacists, and other special guests. On motion (Wolff-

Mauldin) it was voted to pay the expenses of the meeting up to \$1,000.00.

The meeting was adjourned at 5:30 P.M.

Reconvened Meeting

Chairman McDaniel reconvened the meeting on March 26th at 8:30 A.M.

The first order of business was to appoint a committee to make arrangements for the Macon meeting. Chairman McDaniel then appointed Vice President Collins as Chairman, Henry H. Tift and Milford B. Hatcher on the committee.

Industrial Health Committee Report

(a) *Workman's Compensation*: Dr. Peterson gave a progress report a conference with Mr. Lowry of the Workman's Compensation Board, regarding fee schedules. It is Dr. Peterson's impression that the Board will be very cooperative.

(b) *State Employees Physical Examination*: This data will be reported on at a later date.

Committee on Committee Reorganization Report

Drs. Dillinger, Goodwin, and Hatcher made a report on proposed plans of MAG committee reorganization. Their plans were outlined. On motion (Mauldin-Hatcher) it was voted that Dr. Dillinger's committee meet, formulate, and present their plan to the Executive Committee at the April meeting, if possible.

Report of Treasurer

Dr. Arp gave his report on the monthly budget and annual audit for information. On motion duly made and seconded it was voted to accept the report as presented.

Physical Therapy Practice Act

Dr. Mauldin recommended that this be referred to the MAG attorneys to report back to the next Council meeting. On motion duly made and seconded it was so voted.

American Physical Therapy Association Request

Dr. Mauldin read a letter from this Association requesting that two doctors be appointed to the Physical Therapy Association Advisory Board. On motion duly made and seconded it was voted that the President appoint two members to work with this Association.

Resolution on Lee Howard

Dr. Peterson read a Resolution on Dr. Lee Howard. (This resolution was printed in the April, 1961 issue of the *Journal*.)

On motion duly made and seconded it was voted to incorporate this Resolution in the minutes and to send a copy to the family.

AMA Activity Report

Mr. Richard Nelson, AMA Field Representative, gave a report of AMA activities. This was accepted for information.

Kerr-Mills Bill Implementation

It was recommended by Dr. Hatcher that the Secretary send a statement to Governor Vandiver that MAG wishes implementation of the Kerr-Mills Bill at an early date, at least on a limited basis. On motion (Dillinger-Simonton) it was voted that such a letter be delivered to the Governor and that it also be referred to the House of Delegates in the form of a Resolution so that they might implement and present recommendations. Dr. Simon-ton recommended that Dr. Hatcher and a committee visit the Governor about the matter. On motion (Simonton-Peterson) it was voted to authorize the Chairman of Council to appoint a special committee to talk with the Governor and deliver the above mentioned letter.

Headquarters Office Report

Mr. Krueger reported on Headquarters activities, and also discussed the following items:

(a) *Advertisement*: AMA has an advertisement regarding a national campaign to inform the public on the question of where doctors stand regarding medical care for the aged to be published in daily newspapers on April 19th. On motion duly made and seconded it was voted that each county medical society having a daily newspaper within its jurisdiction be requested that

this be done and a letter should be written informing them of this action.

(b) *SAMA*: Mr. Krueger reported on the status of Emory and the Medical College of Georgia participation in attending the SAMA annual meeting.

(c) *Staff Resignations*: (1) Mrs. Anne Kirkland, Managing Editor of the *Journal*, has resigned effective June of 1961. On motion duly made and seconded it was voted to write a letter of appreciation to her to be signed by the President and Chairman of Council. (2) One of the general secretaries will be resigning soon.

AMA Resolutions

Dr. Allen asked for postponement of the reading of Resolutions until the next Council meeting.

Certificates of Appreciation

Chairman McDaniel asked for nominations for Certificates of Appreciation at the Annual Session. Those nominated were: (1) John P. Heard, (2) Milford B. Hatcher, (3) Mrs. W. P. Rhyne, (4) Any Councilor going off Council, (5) Samuel U. Braly, (6) C. J. McLoughlin, (7) Louis M. Orr. On motion duly made and seconded it was voted to give certificates to the above named.

Other Business

(1) *Letter of Appreciation*: It was recommended that a letter be written to Mrs. McDaniel, Mrs. Mauldin, and Mrs. Woody for the decorations at the Cherokee Town and Country Club at the Council Dinner, March 25th. On motion it was voted to do so.

(2) *Dr. Allen*: Dr. Chambers discussed Dr. Allen's campaign for nomination as AMA Vice President. He asked Council to write letters to doctors in distant states about Dr. Allen, and he will also make an announcement at the House of Delegates meeting.

(3) *Health Insurance Council Request*: Secretary Mauldin stated that Mr. Sheffield Owen had asked him to announce at Council meeting that the HIC would like representation on the Mediation Council to assist in adjustment of claims. On motion (Wolff-Alexander) it was voted to refer this matter to the Insurance and Economics Committee.

(4) *Georgia Dental Association*: Dr. W. E. Coleman, President-Elect of the Georgia Dental Association, introduced Dr. Buford Jones, President of the Georgia Dental Association. Dr. Jones stated the Dental Association would lend their support for the Special Meeting in Macon.

(5) *Date and Site of Next Council Meeting*: May 6, 1961, in Atlanta.

Insurance and Economics Committee Report

Dr. Thomas reported on the following:

(a) *Life Coverage*: The Life Insurance Company of Georgia has prepared a questionnaire to go out to the MAG membership regarding an increase in coverage from \$10,000 to \$20,000. The Insurance and Economics Committee voted to offer it to the members. However, there is a negative enrollment proposal, for if the postcard is not answered it is assumed the member wishes to increase the coverage. On motion (Wolff-Elliott) it was voted not to increase the coverage to \$20,000 but retain it at \$10,000.

(b) *Disability Proposal*: It was proposed to increase the disability from \$50.00 to \$100.00 per week. This would double the premium. The Insurance and Economics Committee voted to offer this to MAG membership. On motion (Wolff-Collins) it was voted to approve the increased disability benefits provided there is a positive enrollment to get acknowledgment from each member as to whether he desires the increase or not, and suggested that the Committee ask the insurance company to enclose the reply postcard in the semi-annual premium notice.

(c) *Simpson-Keogh Bill*: Dr. Thomas asked whether the MAG members were interested in sending out a questionnaire regarding income, employees salaries, etc. On motion (Wolff-Hatcher) it was voted to approve the mailing of this questionnaire, and Dr. Thomas is to get the questionnaire mailed locally.

(d) *Widows and Dependents*: Life of Georgia requested the names of widows and dependents of former members of MAG.

Dr. Thomas was informed this was being done through the Woman's Auxiliary.

(e) *Industry Health Care Insurance Plans*: Dr. Thomas asked that every effort be made to encourage industry to make health care insurance available to employees. On motion (Thomas-Alexander) it was voted to approve this idea.

There being no further business, the meeting of the MAG Council was adjourned at 12:40 P.M.

MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE MARCH MEETING OF the Medical Association of Georgia Executive Committee of Council was called to order by Chairman Milford B. Hatcher at 12:45 P.M., March 26, 1961 at the MAG Headquarters Building, Atlanta, Georgia.

The members of the Committee present were: Milford B. Hatcher, Macon, President and Chairman; Fred H. Simonton, Chickamauga, President-Elect; J. G. McDaniel, Atlanta, Chairman of Council; John T. Mauldin, Atlanta, Secretary; Luther H. Wolff, Columbus, Past President, and Virgil B. Williams, Griffin, Chairman of Finance. Also present were Braswell E. Collins, Macon, Second Vice President; Mr. Milton D. Krueger, Executive Secretary, and Mrs. Catherine Wooten, Executive Assistant.

The reading of the minutes of the February meeting was omitted as they had been read at the Council meeting.

Medic-Alert Foundation

Secretary Mauldin read a letter from this organization regarding identification amulets to be worn by patients who have certain diseases about which it would be best to know in case of accidents or emergencies. On motion (McDaniel-Wolff) it was voted to instruct the Secretary to check with AMA and the Better Business Bureau about the manufacturer and the usefulness of these amulets and report back to Executive Committee at the April meeting.

Weekly Health Column

Mr. Krueger asked for replacements on this committee to fill two vacancies. On motion duly made and seconded it was voted to allow the Chairman of this committee to make these selections.

Replacement of Liaison Physician, Georgia State League of Nursing

On motion duly made and seconded it was voted that Secretary Mauldin act as the representative.

A. H. Robins Community Service Award

This award had been declined in the past for reason duly discussed. On motion (Williams-Hatcher) it was voted to disapprove this second request and to inform the company of this action.

Practical Nurse Bill

Mr. Krueger asked for the opinion of the Committee regarding the backing of this bill. On motion duly made and seconded it was voted to table this item.

National Hospital Day

Dr. Hatcher stated that the American Hospital Association would like endorsement by MAG of National Hospital Day. On motion (Wolff-Mauldin) it was voted to authorize the President to carry out the proposed recommendations.

Air Conditioner Expense Report

Dr. Mauldin gave the Committee a report on the actual cost of operation for the past year. It was recommended that a contract for such upkeep be renegotiated as the one submitted did not meet with approval. On motion (Simonton-Williams) it was voted to authorize the Chairman of Council and the Secretary to work out the details of the contract.

Unfinished Business

- (1) *Moffett Letter*: A thank-you letter was read.
- (2) *Bond*: On motion (Mauldin-Simonton) it was voted to purchase the Moffett baby a government bond.
- (3) *Georgia Association of Nursing Homes*: Secretary Mauldin read a letter regarding establishment of nursing home accred-

itation program. On motion (Wolff-Hatcher) it was voted to authorize the Secretary to write a letter to get further information and to meet with a representative of their organization.

(4) *Boy Scouts Meeting Exhibit*: Secretary Mauldin read a letter from the AMA regarding staffing the exhibit on May 7-9, 1961, at Eatonton. As these dates conflict with the MAG Annual Session dates, on motion duly made and seconded it was voted to authorize the Secretary to take whatever action he deems necessary.

New Business

(1) *Date and Site of April Executive Committee Meeting*: April 23, 1961, Macon, Georgia.

There being no further business the meeting was adjourned at 1:30 P.M.

INSURANCE AND ECONOMICS COMMITTEE MEETING

THE MEETING OF THE Insurance and Economics Committee was called to order by Chairman David R. Thomas, Jr. of Augusta at 11:10 A.M., February 26, 1961, at the Dempsey Hotel, Macon, Georgia.

Members of the Committee present included: David R. Thomas, Jr., Augusta, Chairman; Charles S. Jones, Atlanta, Co-Chairman; John L. Elliott, Savannah; George Scheussler, Columbus; H. Hill Hammett, Jr., LaGrange; Herbert M. Olnick, Macon, and Stewart G. Blackshear, Gainesville.

In addition to those members of the Committee present also attending were: Mr. Jack Bragg, Atlanta, Vice President, Life of Georgia and Mr. Ed Lord, Atlanta, Group Manager, Life of Georgia. Also present were Mr. M. D. Krueger, Atlanta, MAG Executive Secretary, and Mr. Karraker, Assistant Trust Officer, Georgia Railroad Bank and Trust Company.

Life of Georgia Insurance Company Report

Chairman Thomas called on Mr. Bragg and Mr. Lord of the Life Insurance Company of Georgia to give a report on the first year's experience of the Association's group plans, the progress of the three plans and future proposals for the plans. The experience on the Term Life Insurance plan, the Health and Accident Loss of Time plan and the Hospital-Nurse Catastrophic plan was discussed in detail with data furnished on earned premiums, insured claims, and loss ratio for the policy period date November 15, 1959 to December 31, 1960. MAG member participation in the various plans was discussed with a special emphasis on the new member enrollment problem. It was recommended that better methods of informing new members of the availability of these plans be investigated. Ways and means of notifying the widows of physicians were discussed and Dr. Thomas volunteered to further stimulate this matter with the President of the Women's Auxiliary to the Medical Association of Georgia.

Certain proposals made by the representatives of the Life Insurance Company of Georgia were as follows:

(1) Raising the benefit amount of term life insurance from \$10,000 to \$20,000 and doubling the premium rate for such coverage.

(2) Increase the amount of health and accident (loss of time)

weekly benefit of \$50.00 to \$100.00 and so double the premium for such coverage.

After due discussion of these two proposals it was voted (Hammett-Jones) that the present participants insured under these two plans be given the choice of retaining either their present coverage or applying for the new coverage and further that new enrollees from the effective date of the new coverage be eligible for the present plan until age 35 at which time the proposed plan would be mandatory. It was further requested in this motion that the MAG attorney investigate whether or not the new coverage be mandatory after age 35 or whether two coverages (present plan and proposed plan) could be available after age 35 under Georgia law.

Hospital-Nurse Catastrophic Premium Rate Change

Both Mr. Bragg and Mr. Lord pointed out that the experience on the Hospital-Nurse catastrophic insurance necessitated a premium increase in that the loss ratio was above and beyond the earned premium. They recommended that such a proposed premium raise be effective May 15, 1961. After general discussion on motion (Jones-Olnick) it was recommended that the proposed raise in the premium coverage for the Hospital-Nurse catastrophic insurance be approved effective May 15, 1961. The committee voted to disapprove this motion.

Pre-Existing Conditions

By general agreement it was recommended that a clarification of pre-existing conditions under the Health and Accident Loss of Time Insurance be further discussed at the next meeting of the Insurance and Economics Committee.

MAG Membership Retirement Plan

After due discussion of various types of retirement plans for the MAG membership, David Thomas recommended that certain data be sought from the MAG membership and the Committee approved the sending out of an "unsigned" questionnaire to members of the Association on matters of income, taxes, etc.

Report of Meetings

Dr. Thomas gave a full and detailed report of two meetings he attended as Chairman of the Insurance and Economics Committee. He reported on the AMA Regional Relative Values Schedule meeting held in Atlanta and an AMA National Congress on Pre-Paid Health Insurance. Committee members discussed the information received at these meetings and the report was accepted for information.

Health Insurance for the Aged

By general agreement the committee recommended that Council consider a resolution to encourage industry to make the same or similar health coverage available to employees upon their retirement, so that they may have the benefit of retaining health insurance after they have been retired by the firm that they are presently employed with. It was recommended that this matter be discussed with Mr. Sheffield Owen of the Georgia Health Insurance Council, the Industrial Health Committee of the Association, and its Health Care of the Aged Committee.

There being no further business the meeting was adjourned at 4:00 P.M.

COMMUNIST THREAT

"FIRST, WE WILL take Eastern Europe, then the masses of Asia, then we will encircle the United States, which will be the last bastion of capitalism. We will not have to attack. It will fall like an overripe fruit into our hands."

Lenin

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Alderman, Earl L.	1968 Peachtree Rd., N.E. Atlanta 9	DE-2	DeKalb
Carlucci, Agostino	1333 Harper St. Augusta	Active	Richmond
Clark, C. Robert	700 Dodds Ave. Chattanooga, Tenn.	Active	Walker-Catoosa-Dade
Cummings, T. E.	121 E. Maple St. Rockmart	Active	Polk
Curtis, Thomas H.	523 Doctors Bldg. Chattanooga, Tenn.	Active	Walker-Catoosa-Dade
Echols, George L., Jr.	Milledgeville State Hosp. Milledgeville	Active	Baldwin
Elrod, Dan B.	101 S. Tallahassee Baxley	Active	Altamaha
Ford, Henry J.	Watkinsville	Active	Crawford Long
Garrett, David G., Jr.	415 Bradford St., N.W. Gainesville	Active	Hall
Grodman, Pyrrha Gladys	265 Ivy St., N.E. Atlanta 3	Active	Fulton
Hahn, Dorothy A.	Talmadge Memorial Hosp. Augusta	Active	Richmond
Hensley, Edgar R.	Corner Church and Council Waynesboro	Active	Burke
Hubbell, Robert W.	Atlanta VA Hosp. Atlanta 19	DE-2	DeKalb
Kirkpatrick, James F., Jr.	Emory University Hosp. Atlanta 22	DE-2	DeKalb
Lang, Walter, Jr.	417 Church St. Valdosta	Active	South Georgia
Lockhart, Malcolm D.	3393 Bouldercrest Rd. Rte. 1 Conley	Active	DeKalb
Luke, Daniel R.	415 Bradford St., N.W. Gainesville	Active	Hall
Mulherin, Joseph A.	P. O. Box 54 Hinesville	Active	Ga. Medical Society
Muse, Andrew D., Jr.	28 Duke St. Jefferson	Active	Jackson-Barrow
Nicholas, Edmund M.	384 Peachtree St., N.E. Atlanta 8	Active	Fulton
North, William D., Jr.	Memorial Hospital Bainbridge	Active	Decatur-Seminole
Nunnally, James T.	101 S. Tallahassee Baxley	Active	Altamaha
Okel, Benjamin B.	Emory University Clinic Atlanta 22	DE-2	DeKalb
Owens, Joseph Lawrence, Jr.	Professional Bldg. Brunswick	Active	Glynn
Patterson, George W.	403 Lumpkin St. Cuthbert	Active	Randolph-Terrell
Peters, Hans Juergen	Medical College of Ga. Augusta	Active	Richmond
Phinizy, John	1407 Gwinnett St. Augusta	Active	Richmond
Smith, Douglas	478 Peachtree St., N.E. Atlanta 8	Active	Carroll-Douglas-Haralson

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107TH ANNUAL SESSION

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(1) Carter, S.: *M. Clin. North America* 37:315, 1953.
(2) Maltby, G. L.: *J. Maine M. A.* 48:257, 1957.
(3) Crawley, J. W.: *M. Clin. North America* 42:317, 1958.

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OFFICIAL PROCEEDINGS

107th Annual Session

of the

MEDICAL ASSOCIATION OF GEORGIA

Atlanta Biltmore Hotel, Atlanta,

May 7-10, 1961

First Session, House of Delegates

Second Session, House of Delegates

First General Business Session

Second General Business Session

Third General Business Session



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FIRST SESSION, HOUSE OF DELEGATES

SUNDAY, MAY 7, 1961

THE FIRST SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker Thomas W. Goodwin, Augusta, at 5:15 P.M. on May 7, 1961, in the Main Meeting Hall, Atlanta Biltmore Hotel, Atlanta, Georgia, in conjunction with the 107th Annual Session of the Medical Association of Georgia.

The Invocation was delivered by Speaker Thomas W. Goodwin.

Following the Invocation, Speaker Goodwin remarked on the order of Business in the Delegates' folders and then proceeded with the business before the House.

Speaker Goodwin called for a preliminary report of delegates' attendance. Don F. Cathcart, Atlanta, Chairman of the House of Delegates Credentials Committee, reported that there was a quorum of 40 members at this time. A complete report made by the Credentials Committee on the attendance at this First Session of the House of Delegates follows:

Attendance

In a compilation of attendance taken from the official roll, 48 county medical societies were represented by their duly elected delegates or alternates. Twenty-six medical societies were not represented at this First Session. Of a total of 144 authorized delegates from their respective medical societies, the official roll showed 102 delegates present at this First Session.

BALDWIN: Melvin E. Smith; BARTOW: W. B. Dillard, Jr.; BIBB: Robert Cato, B. E. Collins, Earl Lewis, E. C. McMillan, Jr., Jule C. Neal, Jr.; BULLOCH-CHANDLER-EVANS: L. H. Griffin; CARROLL-DOUGLAS-HARALSON: Phil C. Astin, Jr., J. I. Vansant; CHEROKEE-PICKENS: C. J. Roper; CLAYTON-FAYETTE: T. J. Busey; COBB: Wilbur Clonts, H. D. Meaders, F. K. Schmidt; COLQUITT: J. P. Tucker; COWETA: George Mixon; DECATUR-SEMINOLE: Charles Stewart; DEKALB: John P. Heard, W. K. Kerr, John Schreeder, L. M. Vinton, Jr.; DOUGHERTY: W. P. Rhyne; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD: Ralph Davis, J. H. Jenkins, John Tate; FULTON: Thos. J. Anderson, Tully Blalock, Don F. Cathcart, William C. Coles, John B. Cross, Walker Curtis, Nicholas Davies, M. Bedford Davis, Mary Dougherty, Major Fowler, Jos. L. Girardeau, John T. Godwin, Hugh Hailey, Haywood N. Hill, Fleming Jolley, J. D. Martin, Jr., J. G. McDaniel, W. W. Moore, Jr.,

Lester Rumble, Jr., Ted L. Staton, August Turner, J. W. Veatch, Jr., R. E. Wells; GEORGIA MEDICAL: J. L. Alexander, Melvin Berlin, Ruskin King; GLYNN: J. B. Mercer, C. A. Wilson; HALL: P. K. Dixon; JACKSON-BARROW: P. T. Scoggins; JEFFERSON: C. R. Williams; JENKINS: A. P. Mulkey; CRAWFORD W. LONG: A. Paul Keller, J. B. Traylor; MCDUFFIE: A. G. LeRoy; MUSCOGEE: Harry Brill, A. B. Conger, J. H. Deaton, A. J. Kravtin, Dave Varner; NEWTON-ROCKDALE: Robert M. Martin, Jr.; OCMULGEE: Wm. E. Coleman; OCONEE VALLEY: J. H. Nicholson; POLK: Don Schmidt; RICHMOND: J. B. Bowen, H. S. Engler, W. A. Fuller, F. N. Harrison, G. M. Kelly, L. O. J. Manganiello, W. L. Sheppard, Jack Waters; SOUTH GEORGIA: Van Bennett, R. L. Stump; SOUTHWEST GEORGIA: R. F. Jennings; SPALDING: Virgil Williams; STEPHENS: I. D. Hellenga; SUMTER: Wm. F. Castellow; TELFAIR: C. J. Maloy; THOMAS-BROOKS: Rudolph Bell, George Dillinger; TROUP: J. M. Grisamore, H. Hilt Hammett, Jr.; UPSON: T. A. Sappington; WARE: W. L. Pomeroy, Leo Smith; WALKER-CATOOSA-DADE: Fred H. Simonton, Warren Terrell; WALTON: Lynn Huie; WASHINGTON: F. T. McElreath; WAYNE: J. W. Yeomans; WHITFIELD: David Wells; WORTH: W. P. Stoner.

County Medical Societies not represented at this session of the House of Delegates were as follows: ALTAMAHA, BEN HILL - IRWIN, BLUE RIDGE, BURKE, CAMDEN - CHARLTON, CHATTAHOOCHEE, CHATTOOGA, COFFEE, FRANKLIN - HART - ELBERT, GORDON, GRADY, JASPER, LAMAR, LAURENS, MERIWETHER-HARRIS, MITCHELL, PEACH BELT, RABUN, RANDOLPH - TERRELL, SCREVEN, SOUTHEAST GEORGIA, TAYLOR, TIFT, TRICOUNTY, WARREN, and WILKES.

Reference Committees

Speaker Goodwin appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE NO. 1: Jule C. Neal, Macon, Chairman; H. E. Weems, Perry, Vice Chairman; Joseph B. Mercer, Brunswick, Secretary; L. O. J. Manganiello, Augusta; Henry D. Meaders, Marietta; Charles C. Lamb, Albany; John B. O'Neal, III, Elberton, and L. G. Hicks, Jr., Clarkesville.

REFERENCE COMMITTEE NO. 2: J. Bothwell Traylor, Athens, Chairman; Tully T. Blalock, At-

lanta, Vice Chairman; Don Schmidt, Cedartown, Secretary; Jack Waters, Augusta; Calder B. Clay, Jr., Macon; James H. Jenkins, Rome; Van B. Bennett, Valdosta; A. G. LeRoy, Thomson, and O. D. Middleton, Ludowici.

REFERENCE COMMITTEE NO. 3: Leo Smith, Waycross, Chairman; J. H. Deaton, Columbus, Vice Chairman; Ralph Davis, Rome, Secretary; Bernard P. Wolff, Atlanta; J. L. Alexander, Savannah; I. D. Hellenga, Toccoa; W. F. Castellow, Americus; Wm. B. Dillard, Jr., Cartersville, and Melvin E. Smith, Milledgeville.

REFERENCE COMMITTEE NO. 4: P. K. Dixon, Gainesville, Chairman; Wm. E. Coleman, Hawkinsville, Vice Chairman; Harry Brill, Columbus, Secretary; F. N. Harrison, Augusta; Irving L. Greenberg, Atlanta; H. Hilt Hammett, Jr., LaGrange; Trammell Starr, Dalton; Robert A. Pumphelly, Jesup, and Lester Rumble, Atlanta.

REFERENCE COMMITTEE NO. 5: John T. Godwin, Atlanta, Chairman; J. B. Bowen, Augusta, Vice Chairman; J. I. Vansant, Villa Rica, Secretary; E. C. McMillan, Jr., Macon; Shelley C. Davis, Atlanta; H. G. Davis, Jr., Sylvester; T. A. Sappington, Thomaston, and R. G. McGahee, Augusta.

Credentials and Tellers Committees

Speaker Godwin announced the prior appointments of the House of Delegates Credentials Committee and Tellers Committee as follows:

Credentials Committee: Don F. Cathcart, Atlanta, Chairman; W. L. Pomeroy, Waycross, and John L. Elliott, Savannah.

Tellers Committee: Walter P. Rhyne, Albany, Chairman; Ruskin King, Savannah, and Paul Scoggins, Commerce.

Approval of 1960 Minutes

To expedite the reading and adoption of the minutes of the 1960 sessions of the House of Delegates held in conjunction with the *106th Annual Session of the Medical Association of Georgia meeting in Columbus, Georgia on May 1-4, 1960, the Chair entertained a motion that the minutes as published in the June 1960 issue of the *Journal of the Medical Association of Georgia* be approved. On motion duly made and seconded, it was voted that these minutes be so approved.

Memorial Service

Speaker Goodwin then introduced Dean Alfred Hardman, Dean of St. Philips Cathedral, Atlanta, who conducted the Memorial Service for the MAG members deceased during the past year. Following this prayer, Speaker Goodwin read the names of the departed colleagues:

CHARLES ROSS ADAMS, Atlanta, April 20, 1960

W. A. ARNOLD, Atlanta, January 9, 1961

D. V. BAILEY, Elberton, December 20, 1960

LEWIS BEASON, Butler, August 8, 1960

PEYTON ELLIOTT BELL, Sylvester, February 11, 1960

G. L. BROADRICK, Dalton, December 6, 1960

J. G. CARTER, Scott, April 21, 1960

BETHEL BRYANT CHANDLER, Lula, October 19, 1960

RALPH H. CHANEY, Augusta, May 3, 1961

J. C. COLLINS, Collins, March 10, 1961

WILLIAM C. COOK, Columbus, October 13, 1960

WILLIAM R. DANCY, Savannah, September 14, 1960

GEORGE WILLIAM DUPREE, Gordon, September 17, 1960

W. FAUST DURDEN, Gainesville, March 9, 1961

GEORGE LEE ECHOLS, Milledgeville, October 23, 1960

ROBERT W. EILERS, Atlanta, May 4, 1961

E. L. EVANS, Tifton, December 3, 1960.

CLAYBORNE ANDERSON HARRIS, The Rock, October 17, 1960

JOHN H. HINES, Roswell, May 28, 1960

CHARLES A. HODGES, Dublin, December 4, 1960

WILLIAM HENRY HOUSTON, Colquitt, August 8, 1960

LEE HOWARD, SR., Savannah, December 14, 1960

STACY C. HOWELL, Atlanta, March 11, 1961

THOMAS CORNELIUS JEFFORD, Sylvester, October 16, 1960

JABEZ JONES, Savannah, December 31, 1960

JAMES BENJAMIN KAY, Byron, June 25, 1960

SPENCER A. KIRKLAND, Atlanta, December 29, 1960

O. T. MALONE, Atlanta, February 24, 1961

E. N. MANER, Savannah, March 23, 1961

JOHN TINKHAN MANTER, Augusta, November 5, 1960

W. P. MARTIN, Summerville, January 10, 1961

W. R. McCALL, LaGrange, May 27, 1960

W. EDGAR McCURRY, Hartwell, October 28, 1960

E. M. McDONALD, Winder, March 23, 1961

J. L. MITCHELL, Decatur, January 23, 1960

WILLIAM DANIEL MIXSON, Waycross, June 2, 1960

Q. A. MULKEY, Millen, April 7, 1960

T. C. NASH, Philomath, April 4, 1961

WELDON E. PERSON, Atlanta, May 14, 1960

JAMES CARL PIRKLE, Milledgeville, September 14, 1960

B. O. QUILLIAN, Douglas, January 17, 1961
 HUBERT RAWISZER, Atlanta, May 2, 1960
 W. H. ROBERTS, Augusta, February 15, 1961
 JOHN E. SAADE, Augusta, November 20, 1960
 WILLIAM ASBERRY SEWELL, Rome, June 22, 1960
 WILLIAM WALTER SHARPE, III, Alma, November 16, 1960
 DAVID MARION SILVER, Augusta, June 14, 1960
 WILLIAM KIRK SWANN, Covington, August 29, 1960
 JOHN L. TAYLOR, Franklin, July 18, 1960
 W. H. WHITTENDALE, Norman Park, November 10, 1960
 M. E. WINCHESTER, Brunswick, December 24, 1960
 Y. HARRIS YARBROUGH, Milledgeville, October 24, 1960

Resignation of Speaker

Speaker Thomas Goodwin, of Augusta, advised the delegates that at this time he wished to tender his resignation as Speaker of the MAG House of Delegates. Dr. Goodwin explained that as he had been nominated and elected to the office of MAG President-Elect, he felt it fitting and proper to resign as Speaker of the House, so that no one officer would hold two such MAG offices at the same time. Dr. Goodwin cited the MAG Constitution and Bylaws, Chapter VI, Section 7 as follows: "In the event of the Speaker's death, resignation or inability to serve, the Vice Speaker shall succeed him for the unexpired term."

Dr. Goodwin then declared Vice Speaker J. Frank Walker, of Atlanta, as the new Speaker of the MAG House to fill the unexpired term of one year due to the resignation of Speaker Goodwin who resigned.

At this time J. Frank Walker, of Atlanta, became Speaker of the House and proceeded with the order of business.

Annual Reports

Speaker Walker called for the Annual Reports of the Officers, Council, Councilors, and Committees as the next item of business.

(A cross reference of the reports of the Officers, Council, Councilors, Committees, and Allied Reports as introduced at this session is listed below with the Reference Committee to which they were referred. The full report, the action by the Reference Committees, and the House of Delegates action is listed under the proceedings of the Second Session of the House of Delegates. See pages 272 to 313.)

REPORTS OF OFFICERS

President—Milford B. Hatcher, Macon—Reference Committee No. 1—See Page 273.

President-Elect—Fred H. Simonton, Chickamauga—Reference Committee No. 1—See Page 275.

Immediate Past President—Luther H. Wolff, Columbus—Reference Committee No. 1—See Page 276.

Second Vice President—Braswell E. Collins, Macon—Reference Committee No. 1—See Page 277.

Secretary—John T. Mauldin, Atlanta—Reference Committee No. 2—See Page 281.

Treasurer—C. Raymond Arp, Atlanta—Reference Committee No. 2—See Page 282.

Speaker of the House—Thomas W. Goodwin, Augusta—Reference Committee No. 2—See Page 285.

Vice Speaker of the House—J. Frank Walker, Atlanta—Reference Committee No. 2—See Page 285.

AMA Delegates—Eustace A. Allen, Atlanta, Henry Tift, Macon, and J. W. Chambers, LaGrange—Reference Committee No. 3—See Page 291.

REPORT OF COUNCIL

Report of Council—J. G. McDaniel, Atlanta, Chairman—Reference Committee No. 3—See Page 291.

REPORTS OF COUNCILORS AND VICE COUNCILORS

First District Councilor—Charles T. Brown, Guyton—Reference Committee No. 3—See Page 295.

First District Vice Councilor—T. A. Peterson, Savannah—Reference Committee No. 3—See Page 295.

Second District Councilor—George R. Dillinger, Thomasville—Reference Committee No. 3—See Page 296.

Third District Councilor—W. G. Elliott, Cuthbert—Reference Committee No. 4—See Page 304.

Fourth District Councilor—Virgil B. Williams, Griffin—Reference Committee No. 4—See Page 305.

Fifth District Councilor—J. G. McDaniel, Atlanta—Reference Committee No. 4—See Page 305.

Sixth District Councilor—George H. Alexander, Forsyth—Reference Committee No. 4—See Page 305.

Seventh District Councilor—Ralph W. Fowler, Marietta—Reference Committee No. 5—See Page 308.

Eighth District Councilor—F. G. Eldridge, Valdosta—Reference Committee No. 5—See Page 309.

Eighth District Vice Councilor—James M. Hicks, Brunswick—Reference Committee No. 5—See Page 309.

Ninth District Councilor—Charles R. Andrews, Canton—Reference Committee No. 5—See Page 309.

Ninth District Vice Councilor—Paul T. Scoggins, Commerce—Reference Committee No. 5—See Page 310.

Tenth District Councilor—Addison Simpson, Jr., Washington—Reference Committee No. 5—See Page 310.

REPORTS OF COMMITTEES

Cancer—Hoke Wammock, Augusta, Chairman—Reference Committee No. 3—See Page 296.

Constitution and Bylaws—Thomas W. Goodwin, Augusta, Chairman—Reference Committee No. 3—See Page 297.

Crawford W. Long Memorial—Lester Rumble, Atlanta, Chairman—Reference Committee No. 1—See Page 277.

Hospital Relations—David Henry Poer, Atlanta, Chairman—Reference Committee No. 5—See Page 310.

Industrial Health—T. A. Peterson, Savannah, Chairman—Reference Committee No. 2—See Page 285.

Insurance and Economics—David R. Thomas, Augusta, Chairman — Reference Committee No. 2—See Page 285.

Legislation—John A. Bell, Jr., Dublin, Chairman — Reference Committee No. 1—See Page 277.

Maternal and Infant Welfare—Eugene Griffin, Atlanta, Chairman — Reference Committee No. 3—See Page 297.

Medical Defense—Charles S. Jones, Atlanta, Chairman—Reference Committee No. 3—See Page 298.

Mental Health—R. J. Van de Wetering, Atlanta, Chairman — Reference Committee No. 4—See Page 306.

Professional Conduct—William Harbin, Rome, Chairman—Reference Committee No. 4—See Page 306.

Public Health—Virgil Williams, Griffin, Chairman — Reference Committee No. 4—See Page 306.

Public Service—John P. Heard, Decatur, Chairman —Reference Committee No. 2—See Page 287.

Rural Health—Albert L. Morris, Fairburn, Chairman—Reference Committee No. 5—See Page 311.

Scientific Exhibit Awards—Ted F. Leigh, Atlanta, Chairman — Reference Committee No. 5—See Page 311.

Veterans Affairs—Lee Howard, Jr., Savannah, Chairman—Reference Committee No. 1—See Page 278.

Woman's Auxiliary Advisory—Virgil B. Williams, Griffin, Chairman—Reference Committee No. 2—See Page 288.

SPECIAL COMMITTEES

Crippled Children—J. C. Hughston, Columbus, Chairman — Reference Committee No. 3—See Page 298.

Medical Civil Preparedness—E. M. Dunstan, Atlanta, Chairman — Reference Committee No. 4—See Page 306.

Ministerial Liaison—Needham B. Bateman, Atlanta, Chairman — Reference Committee No. 5—See Page 312.

Rehabilitation—Robert Bennett, Warm Springs, Chairman — Reference Committee No. 1—See Page 279.

School Child Health—Grady Black, Griffin, Chairman — Reference Committee No. 2—See Page 288.

VFW Liaison—Charles Andrews, Canton, Chairman — Reference Committee No. 1—See Page 279.

Weekly Health Column—August S. Yochem, Atlanta, Chairman — Reference Committee No. 4—See Page 307.

ALLIED REPORTS

Journal of the Medical Association of Georgia — Edgar Woody, Jr., Editor and Mrs. Anne W. Kirkland, Managing Editor, Atlanta — Reference Committee No. 5—See Page 312.

Woman's Auxiliary to the Medical Association of Georgia—Mrs. W. P. Rhyne, Albany, President — Reference Committee No. 2—See Page 289.

At the completion of the report of the Woman's Auxiliary to the Medical Association of Georgia given by Auxiliary President Mrs. W. P. Rhyne, a standing

vote of appreciation was given to the Auxiliary officers and membership for their activity during the year 1960-61.

General Practitioner of the Year Award

Speaker Walker presented the nominations received for the "1961 Georgia General Practitioner of the Year Award." The following names were read: H. B. Bradford, of Cartersville, and J. W. Palmer, of Ailey. Speaker Walker then requested that a vote by secret ballot be taken by the House of Delegates with the House Tellers Committee collecting and counting the ballots. Tellers Committee Chairman W. P. Rhyne announced the following results: J. W. Palmer, Ailey, elected "1961 Georgia General Practitioner of the Year."

Hardman Award

Speaker Walker presented the nominations received for the Hardman Award. These nominations were: Rudolph Bartholomew, Atlanta, and Robert C. Pendergrass, Americus. Speaker Walker then requested a vote by secret ballot be taken by the House of Delegates and collected and counted by the Tellers Committee. Tellers Committee Chairman W. P. Rhyne announced the following results: Robert C. Pendergrass, Americus, elected the 1961 recipient of the "Hardman Award."

Supplementary Reports

Speaker Walker then called for new business and as the first order of new business requested any Supplementary Reports from Officers, Council, Councilors or Committees and the following reports were then introduced:

Supplementary Report of the President No. A: Health Care of the Aged—Milford B. Hatcher, Macon — Referred to Reference Committee No. 1—See Page 279.

Supplementary Report of the Constitution and By-laws No. B: Committee Reorganization—Thomas W. Goodwin, Augusta, Chairman — Referred to Reference Committee No. 3—See Page 299.

Resolutions

Speaker Walker then called for Resolutions as the second order of new business and the following Resolutions were so introduced:

Resolution No. 1: AMA Support by Individual Physicians—Coweta County Medical Society — Referred to Reference Committee No. 1—See Page 280.

Resolution No. 2: Good Samaritan Laws Legislation—Spalding County Medical Society — Reference Committee No. 1—See Page 280.

Resolution No. 3: Blue Cross Professional Services Coverage—Thomas J. Anderson, Jr., Delegate, Fulton County Medical Society — Reference Committee No. 2—See Page 287.

Resolution No. 4: Marriage Laws Legislation—Mus-

cogee County Medical Society — Reference Committee No. 1—See Page 280.

Resolution No. 5: Establishment of Burn Center—Oconee Valley Medical Society — Reference Committee No. 4—See Page 308.

Speaker Walker called for other Resolutions and there being none, he then called on President Milford B. Hatcher.

President Milford B. Hatcher introduced Dr. Leonard Larson, AMA President-Elect, who addressed the House of Delegates on the subject "Your AMA-1961."

Following the address by Dr. Larson, Speaker Walker called the first meeting of the MAG House of Delegates recessed at 6:10 P.M.

SECOND SESSION, HOUSE OF DELEGATES

(Recessed)

WEDNESDAY, MAY 10, 1961

THE SECOND SESSION (Recessed) of the House of Delegates of the Medical Association of Georgia, held in conjunction with the 107th Annual Session of the Association, was called to order by Speaker J. Frank Walker at 9:05 A.M., Wednesday, May 10, 1961 in the Main Meeting Hall of the Atlanta Biltmore Hotel, Atlanta, Georgia.

Speaker Walker called on Credentials Committee Chairman Don Cathcart for a preliminary report of attendance. Dr. Cathcart reported that more than 40 members of the House of Delegates were registered as present and Speaker Walker then declared a quorum present and accounted for, and the House in session. Dr. Cathcart later made the following complete report on attendance:

Attendance

In a compilation of attendance taken from the official roll, 37 county medical societies were represented by their duly elected delegates or alternates. Thirty-seven county medical societies had no representatives at the Second Session. Of a total of 144 authorized delegates from their respective county medical societies, the official roll showed 74 delegates present at this Second Session.

BALDWIN: Melvin E. Smith; BARTOW: W. B. Dillard; BIBB: Braswell E. Collins, W. Earl Lewis, E. C. McMillan, Jr., Jule C. Neal, Jr.; BULLOCH-CANDLER-EVANS: L. H. Griffin; CARROLL-DOUGLAS-HARALSON: Phil C. Astin, Jr., J. I.

Vansant; CHEROKEE-PICKENS: C. J. Roper; CLAYTON-FAYETTE: T. J. Busey; COBB: W. T. Clonts, H. W. Meaders; COWETA: George E. Mixon; CRAWFORD W. LONG: A. P. Keller, Jr., Bothwell Traylor; DECATUR-SEMINOLE: C. C. Stewart; DEKALB: W. K. Kerr, John M. Schreeder, Luther M. Vinton, Jr.; EMANUEL: R. J. Moye; FLOYD: James H. Jenkins; FULTON: Don F. Cathcart, John B. Cross, W. L. Curtis, M. Bedford Davis, Jr., Shelley C. Davis, Edwin C. Evans, Major F. Fowler, John T. Godwin, Haywood N. Hill, Fleming Jolley, J. D. Martin, J. G. McDaniel, Ted L. Staton, Lester Rumble, Jr., August B. Turner, J. W. Veatch, Jr., R. E. Wells; GEORGIA MEDICAL: J. W. Alexander, Melvin Berlin, Ruskin King; GLYNN: C. A. Wilson, Jr.; HABERSHAM: Bruce Swain; HALL: P. K. Dixon; JACKSON-BARROW: Paul T. Scoggins; JASPER: E. M. Lancaster; MCDUFFIE: A. G. LeRoy; MERIWETHER-HARRIS: William G. Chambliss; MUSCOGEE: Harry Brill, A. B. Conger, John H. Deaton, A. J. Kravtin, W. D. Varner; OCMULGEE: Wm. E. Coleman; PEACH BELT: A. E. Weems, Jr.; RICHMOND: John B. Bowen, Harold Engler, Wm. A. Fuller, F. N. Harrison, Gordon M. Kelly, Walter L. Sheppard, SOUTH GEORGIA: Van B. Bennett; SPALDING: Virgil Williams; STEPHENS: I. D. Hellenga; SUMTER: C. P. Savage; THOMAS-BROOKS: Rudolph Bell, George Dillinger; TROUP: J. M. Grisamore; WALKER-CATOOSA-DADE:

Fred K. Schmidt, Warren Terrell; WARE: W. L. Pomeroy; Leo Smith; WAYNE: J. W. Yeomans; WHITFIELD: David Wells.

County medical societies not represented at this Second Session of the House of Delegates are as follows: ALTAMAHA, BEN HILL-IRWIN, BLUE RIDGE, BURKE, CAMDEN - CHARLTON, CHATTAHOOCHEE, CHATTOOGA, COFFEE, DOUGHERTY, FRANKLIN - HART - ELBERT, FLINT, GORDON, GRADY, JEFFERSON, JENKINS, LAMAR, LAURENS, MITCHELL, NEWTON, OCONEE VALLEY, POLK, RABUN, RANDOLPH - TERRELL, SCREVEN, SOUTH-EAST GEORGIA, SOUTHWEST GEORGIA, TAYLOR, TELFAIR, TIFT, TRI-COUNTY, UPSON, WALTON, WARREN, WASHINGTON, WILKES, and WORTH.

Reference Committee Reports

Speaker J. Frank Walker stated that the next order of business would be the Reference Committee Reports. He requested that the members of the House consider and deliberate the recommendations as presented by the five Reference Committees, so that the actions of the House may be in accord with the wishes of the entire MAG membership.

Report of Reference Committee No. 1

Jule C. Neal, M.D., Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 1 met in Room 1007 at the Atlanta Biltmore Hotel, May 8, 1961. Members present were: Jule C. Neal, Macon, Chairman; H. E. Weems, Perry, Vice Chairman; Joseph B. Mercer, Brunswick, Secretary; L. O. J. Manganiello, Augusta; Henry D. Meaders, Marietta, and Charles Lamb, Albany.

PRESIDENT

MILFORD B. HATCHER, M.D., Macon

Caught in the throes of the world-wide political and humanitarian revolution, the Medical Association of Georgia officers and staff, not of their own choosing but of necessity, have had to spend a considerable amount of time and effort in combating those who have attempted to change not only our system of practice of medicine but, in the opinion of your President, the entire system of individual achievement of this country. From a medical standpoint we cannot divorce the role played by the physician from the complex life that we

have today. Thus, we are caught in this web of circumstances due to our socio-economic and political life in which changes affecting every aspect of human life are occurring at an ever-accelerating rate. Not only do I feel that we are combating the socialization of medicine, but I feel that we are participating in a struggle for the preservation of our democratic form of government which has been set up in the years past and which is our responsibility to preserve.

The transition of moving into our new building has proceeded with the utmost ease, and, in general, the Association's activities are running very smoothly. As far as I know, there has not been any major conflict between any components of the Association, and the officers and staff have been able to assist in innumerable problems regarding health care throughout the State. One problem has been assisting the smaller communities in the rural areas in getting adequate medical care. I feel that members of the Association could aid in helping some of the smaller communities realize that it is more desirable that we have expanded medical facilities in certain central areas, which may seem more distant than they desire; however, the facilities can be better equipped and staffed and better medical care given, particularly with the excellent roads and transportation available today.

The Georgia Hospital-Medical Council accreditation program is moving forward, whereby more of the smaller hospitals are being approved. The hospitals and communities are cooperating very satisfactorily, and it is felt that the patients are the beneficiaries. The cooperation of all concerned is further requested.

The standing and special committees of the Association have certainly acted in a commendable manner. Practically every major committee has carried out its function during the year, and those which have not met during the current year have given reasons why there was really no indication for their meeting during the year. The majority of these are ones where it is not necessary that they meet except when a special occasion or situation arises. I will not elaborate on the activity of each committee, for this will be given in that committee report.

Last year I requested a reorganization of the committees of the Association. At the present time there are too many committees performing the same function without knowing that other committees are working on the same project, with a chain of command that is loosely organized. If the committees were organized with a much simpler chain of command and organization, the Association officers and Council could be better enlightened on the committee activities, and a more efficient organization would develop.

One problem which I feel is getting worse and which I think the members of the Association should attempt to curb now before it gets pernicious is that of malpractice claims against physicians. It appears to be on the increase in the State. After a considerable amount of study regarding this problem, your President feels that the most feasible method would be to set up a system of reviewing boards whereby members of the legal profession, insurance carriers, and physicians would attempt to solve each case prior to carrying it to court. It is my suggestion that the MAG explore the possibility of three boards being set up,

one in the northern part of the State, one in the central part of the State, and one in the southern part. The exact composition of these boards should be worked out by a committee from our Association with the other two groups mentioned. When a doctor receives notification that one of his patients feels that he has made himself liable for a malpractice claim, if it cannot be settled amicably, it should be presented before this Board for evaluation and recommendation before a suit is filed.

Information should be better disseminated to the members of the Association as to the best course to follow when a physician gets a letter, threatening note, or anything suggestive of suit. He should be told to immediately contact the Headquarters office of the MAG or his insurance carrier prior to seeking advice or information elsewhere.

While discussing insurance problems, I feel that we should request more cooperation between the Insurance Council of Georgia and the Medical Association. I feel that the physicians of the State do not realize how much it has been to their advantage to help the insurance industry and to properly fill out insurance forms and cooperate with the insurance companies to the utmost. The increase in insurance has been a life-saver to hospitals as well as physicians, not only as a strong factor in keeping down socialization of medicine and providing better medical care for many people, but also from a financial standpoint to the physicians. I am afraid the public as well as physicians are killing the "goose that laid the golden egg." It is of the utmost importance that health insurance with free choice of coverage, hospital, and physician be maintained.

The road should also be open both ways, and I feel that the insurance companies through their Insurance Council should attempt to keep their forms simple, requiring the least possible information that will adequately cover the claims and keep their contacts with the physician to a minimum. It should further be stressed to the Insurance Council that too often their agents tell patients that the physician did not fill their form out properly when the company does not "pay off." This has brought more contention and trouble between insurance companies, patients, and doctors than almost any other complaint I have heard. It should be stressed to the Insurance Council that it is up to the insurance company and its agents to explain the policy coverage to the insured and what benefits they may expect, and if it does not pay let them know that it is due to the type policy they bought and not the way that the physician filled out the form.

A number of related organizations, such as the physiotherapists and chiroprodists, have requested better liaison with the MAG. We should have better liaison and collaboration with these supporting organizations and give them guidance, for it is my feeling that if we do not, we will not have any way whereby we can guide them toward the most coordinated and ethical practice. There is much need for better liaison with the dentists, pharmacists, and allied professions. We should have better liaison from a state-wide relationship; however, it would be to the advantage of all concerned if not only from a state level but also in the districts the allied groups could have a social function about once or more a year where they could be-

come better acquainted and open ways for better understanding of the other's problems.

A relative value study committee for physicians' fees has been appointed, and it is to give a preliminary report by the time of the State meeting in Atlanta. It is the feeling of your President that this should be prepared and information obtained in case at any time in the very near future it should become necessary to resort to this type of negotiating in the economic affairs of medical practice.

Prior to this year the AMA delegates and other representatives from the State who attended the meeting of the AMA House of Delegates, etc., did not have anyone delegated to coordinate the activities. Now one individual is delegated by Council for the year to coordinate these activities in relation to the AMA meetings. If any of you are planning on attending the national meeting, it may be to the advantage of all concerned to let MAG headquarters know.

There has not been proper liaison and cooperation between the AMA and the State associations. This year your President has not been approached by members of the AMA staff sufficiently to discuss the feelings, actions, and reactions of the physicians of the State of Georgia. Data and information is sent out from the AMA headquarters, and it is my feeling that some of it should be credited or carrying the stamp of the state organizations, as the more local certain information seems the more valuable it can prove. Information of this sort would mean much more to all concerned, and it would negate the oft-heard remark that the AMA does not really represent the thinking of the individual American physician. The image of the AMA has not been to the advantage of the American physician. In my opinion, something has been wrong. The individual physician should concern himself more with the state and national office and vice versa.

The importance of our national problems in regard to medical care being legislated under the Social Security Administration cannot be over-emphasized. I cannot help but feel if so legislated that this is the first step toward the socialization of medicine. Your officers and members of the staff have had innumerable conferences, conversations, and correspondence with your legislators, national and state, in regard to legislation which has been passed and which is anticipated. We sincerely request your support and your lay friends' support to keep medicine as free from political control as possible.

There was considerable pressure brought upon Congress and members of the medical profession that some type legislation should be passed providing medical care, particularly for the medically needy aged of this country. In taking a realistic viewpoint and attempting to keep the historic American concept of doctor-patient and federal-state relationships, the best solution was that presented in the Kerr-Mills Bill. Your Council and officers endorsed the Kerr-Mills Bill which was passed by Congress in the summer of 1960 for the care of the aged. This we felt was an answer to the health problem of the aged.

Unfortunately, health care, particularly of the aged, during this past year developed into a paramount political issue. This bill recognizes society's obligation

to provide for those who cannot provide for themselves. In the words of Senator Herman Talmadge, "The question for me was not whether legislation on the subject should be enacted but rather what safeguards it should contain to make certain that it would not later prove to be opening wedge for socialized medicine in this country. This bill is (1) voluntary; (2) limited to the needy poor; (3) a federal-state matching program under state control; (4) financed from general revenue tax rather than payroll tax; (5) preserves the right of the patient to choose his doctor and hospital, and (6) preserves the right of the doctor to determine his own practice."

A bill has been passed by your State legislature to implement the Kerr-Mills Bill, and I feel that as soon as possible Georgia should "get going" on this program to show that it can work and will work. If not, I feel that further legislation as mentioned earlier on Social Security lines will be passed. So frequently I have heard our legislators time and again state that "organized medicine should come up with the answer" due to the fact that their constituents feel that they want some type of prepaid medical care. It is the opinion of your President that coverage through private enterprise would be most expeditious, more practical, and best for all concerned. It is my understanding that the AMA and the Insurance Council of America are attempting to help solve this problem.

Efforts have been made this year to bring about a closer liaison and understanding between medical education and the Association, and I feel that some real progress has been made in this area. I recommend continued effort on the part of both the Association and medical educators toward this end.

The establishment of a Burn Center has not progressed very satisfactorily. There are many ramifications and problems which arise; namely, finance, personnel, location, facilities, etc. This is one problem that should be further pursued, and it may be that it can be worked out at a later date.

The reports of the survey made by your President of the mayors and editors of the State is very enlightening. A final tabulation of this will be reported to the Council.

I have not put in my report information concerning the Association which will be in other reports, such as the White House Conference on Health Care of the Aged, Headquarters, and the various and sundry committees which we have appointed and which are working well.

I wish to commend the Secretary of the Association who acted as Chairman of the Governor's Commission on Aging for the fine work which he did in organizing and correlating the thinking of the members of the Governor's Commission. He was ably assisted by the Chairman of the Committee on Aging, Dr. John Atwater, and Dr. J. W. Chambers who was appointed to the committee by the Governor to work out the bill for the implementation of the Kerr-Mills Law. These matters will be covered more fully in reports of these respective individuals.

I wish at this time to take the opportunity to thank the members of the Medical Association of Georgia

who furnished me such an outstanding Council, staff, and committees for this year's work. I regret very much that Mr. John Kiser saw fit to go with the AMA; however, his place has certainly been ably taken by Mr. Jim Moffett, who has stepped right into Mr. Kiser's work very effectively. My gratitude and thanks are extended to Mr. Krueger and his staff for their full cooperation and consideration shown me during the past year.

I will not burden this House of Delegates which has much business to transact with the details or list of meetings I have attended during the year as your President. I have attended as many as time and opportunity would permit. I wish to take this opportunity to thank you for allowing me the privilege of serving as your President. I will be the first to admit that there is much to be attained in the future, but I do feel that we are making strides toward improvement of medical care and of the health of the people of the State of Georgia. I earnestly request the cooperation of each member of the Association and staff with the one you have selected as your most able incoming President, Dr. Fred Simon-ton.

REFERENCE COMMITTEE RECOMMENDATION — Dr. Hatcher's excellent report was approved and commended by this Reference Committee and this Committee would like to take this opportunity to express our gratitude for the tremendous amount of effort he has put forth for us in the past year.

HOUSE OF DELEGATES ACTION — Adopted the report of the President as recommended by the Reference Committee on motion duly made and seconded.

PRESIDENT-ELECT

FRED H. SIMONTON, M.D., *Chickamauga*

Your President-Elect has spent an extremely busy year with the various meetings of the Medical Association of Georgia and with many of its allied activities. He attended all Council and Executive Committee meetings and as many others as was possible including county and district medical meetings.

November 1, 1960, saw him attending the Clinical Session of the American Medical Association in Washington. The following month your President-Elect attended a meeting in Atlanta for County Officers and Secretaries held under the auspices of Chairman John P. Heard and the Committee on Public Service. He feels this was a fine, worthwhile program and recommends that these meetings be continued at intervals.

In January 1961 he attended the President's White House Conference on Aging. In February and early March your President-Elect returned to Washington together with Dr. John T. Mauldin, Dr. John Bell, and Mr. James M. Moffett to represent the Medical Association of Georgia in a conference with Senators Russell and Talmadge and most of our Georgia Representatives regarding the imminent "Medical Aid for the Aged" legislation. This group was impressed with the feelings of these men at that time regarding the Kennedy legislation.

Of paramount importance to us at this time is the implementation of the Kerr-Mills Law at the State

level. The Social Security approach to medical aid to the aging, proposed by President Kennedy, does not offer as much to the needy and near needy as does the Kerr-Mills Law.

Of equal importance and proportion is Georgia's Mental Health Program with its large and varied field. MAG has contributed greatly to the progress made in this field in the State of Georgia, but we still have a long way to go and there remains much room for advancement.

In addition to our concern with Medical Assistance to the Aged, chronic disease, and the Mental Health Program, your President-Elect recommends the reorganization of some of the committees within the Association. He feels that more efficient work may be realized from these organizational changes.

Your President-Elect recommends more attention be given to the supply and placement of our new physicians. The links within the chain of the Medical Association of Georgia, that is, the county medical societies, should be strengthened, and a continuing educational program among the profession and the public should be strengthened to improve relationships.

It is also suggested that MAG should have closer cooperation with other organizations; i.e., Georgia Hospital Association, Georgia Association of Nursing Homes, Georgia Pharmaceutical Association, Chambers of Commerce, farm groups, and other civic groups. By this move the aims of the Medical Association of Georgia will be better known and understood and the public will be better informed from a health standpoint.

The Association must maintain and improve its liaison at the county, state, and national level on legislative matters. When legislation affecting the health and well-being of the citizens of this State is pending, MAG must take the initiative to determine if such legislation is in their best interest.

During the next 12 months it will be my policy to vigorously pursue an extensive visitation program which will take me into as many district and county societies as possible. My purpose for this intensified program is twofold. First, I believe that the Medical Association of Georgia derives its great strength and its life blood from these societies. To honor my obligations and to discharge my responsibilities as your President it is absolutely essential that our meetings and consultations be frequent and be conducted at the working, grass roots level. We face common problems and the solutions to these problems shall be my supreme challenge. To meet this challenge with vigor, enthusiasm, determination, and confidence will be the cornerstone of all my activities during the next 12 months.

Secondly, I believe the biggest problem confronting MAG and the entire medical profession is that of government intervention. I further believe that this problem is the result of activities of self-seeking politicians, who in their quest for votes are playing fast and loose with the historical freedom of the medical profession. The time has come when positive steps must be taken to combat this threat. No longer can political leadership and political decisions affecting the survival of free medicine be left to chance. Rather, the election of candidates for public office and the voting records

of candidates must now, of necessity, be subject to careful scrutiny by physicians both individually and in groups.

During my frequent visits to district and county societies in the next 12 months I will take the opportunity to expound on programs designed to obtain maximum participation in the election of political candidates—to insure that the voice of medicine is heard at the ballot box and in the chambers of existing public officials. Specifically, I plan to present to district and county societies a program tailored to accomplish these objectives.

REFERENCE COMMITTEE RECOMMENDATION — Dr. Simonton's report is approved and he is commended for his past efforts and for his plans for the future.

HOUSE OF DELEGATES ACTION — Adopted the report of the President-Elect as recommended by the Reference Committee on motion duly made and seconded.

IMMEDIATE PAST-PRESIDENT

LUTHER H. WOLFF, M.D., *Columbus*

The role of the Immediate Past-President in the affairs of the Medical Association of Georgia is one that can be viewed with mixed emotions. On the one hand, no one, who has had the signal honor of being President of this great organization can escape a feeling of tremendous relief and sensation of freedom from the arduous duties and grave responsibilities that have been his during his year as President.

On the other hand, the abrupt transition from "running the show" to that of an advisor and often an observer's role leaves one somewhat at a loss. However, this is as it should be. The Medical Association of Georgia has practically unlimited resources in man power and talent, and the more this talent is used the stronger the organization will be.

The year 1960-1961 has been a great and progressive year for the Medical Association of Georgia. The officers, staff, and membership of the organization have performed splendidly. The greatest achievement as far as I am concerned is the fact that no compulsory Federal medical legislation has yet been passed, in spite of seemingly overwhelming pressure. I can only urge everyone to continue the good fight, however heavy the odds and gloomy the outlook.

The reputation and weight of the Medical Association of Georgia continues to grow in health matters. The advice and counsel of the Association is sought from every side, and from many organizations and individuals.

In my opinion, the Medical Association of Georgia will continue to be strong and just, and will be the recognized leader in health affairs in Georgia.

As far as my personal recommendations for changes are concerned, there are none of any consequence. The organization is working smoothly and efficiently.

In regard to my personal activities, I have attended all Council meetings and Executive meetings, and have voiced my opinions. These opinions may or may

not have been correct, but they were always accepted with kindness and consideration.

Lastly, I want publicly to express my appreciation of the work of our President, Dr. Hatcher, of our Chairman of Council, Dr. McDaniel, of our Secretary, Dr. Mauldin, and of our staff, committees, and membership at large for the excellent work that has been done during the past year.

REFERENCE COMMITTEE RECOMMENDATION — The Committee thanks Dr. Wolff for his report and approves and commends this report.

HOUSE OF DELEGATES ACTION — Adopted the report of the Immediate Past President as recommended by the Reference Committee on motion duly made and seconded.

SECOND VICE-PRESIDENT

BRASWELL E. COLLINS, M.D., *Macon*

Attendance at all the Council meetings held during the year with active participation in discussion groups and projects.

Attendance at the formal opening of the Food and Drug Administration Building in Atlanta as official representative of the MAG.

Served on the Committee on Reorganization with committee chairman, Dr. George Dillinger, to submit plans for reorganization of MAG.

Served as representative of MAG on the Inter-professional Council of Georgia. This Council is composed of MAG, Georgia Dental Association, and the Georgia Pharmaceutical Association.

My recommendation for MAG is to change the by-laws to fit the situation, that if the President of MAG were to become incapacitated, he would be succeeded by the Chairman of Council for the remainder of that year.

REFERENCE COMMITTEE RECOMMENDATION — Dr. Collins' report is approved and commended with the additional recommendation that the last paragraph of his report concerning emergency succession to the presidency be referred to the Constitution and Bylaws Committee for their consideration.

HOUSE OF DELEGATES ACTION — Adopted the report of the Second Vice President as recommended by the Reference Committee on motion duly made and seconded.

CRAWFORD W. LONG MEMORIAL

LESTER RUMBLE, JR., M.D., *Chairman*

Thanks to the continued cooperation of all physicians, both as individuals and through the medium of the Medical Association of Georgia, the Crawford W. Long Memorial Museum is still active. Recently, arrangements have been made through the Georgia Historical Commission to redecorate the inside of the building and this work will be carried out and completed, I hope, by the time this report is read. Provisions still have not been made for enlarging this project along the lines which have been outlined before; however,

hope is still alive. It is entirely possible that this year will see the culmination of that desire. The recently established Bureau of Museum Maintenance in the State will help to some degree with the problems encountered in keeping the building intact; however, the need for financial support is still as it has been.

Your Chairman has been derelict in not calling a meeting of the full Committee well prior to this time, but it is anticipated that a meeting of the Committee will be held at the 1961 meeting in Atlanta, hoping that other members will begin to take an active interest in the progress of this project.

REFERENCE COMMITTEE RECOMMENDATION — Dr. Rumble's report was approved and commended with the additional recommendation of this Reference Committee that in view of the recent closing of the Crawford W. Long Memorial, further action in this matter be handled by Council.

HOUSE OF DELEGATES ACTION — At this time Speaker Walker recognized Chairman Lester Rumble of the Crawford W. Long Memorial Committee who presented information on the recent reopening of the Crawford W. Long Memorial. His report was accepted for information only. The House then adopted the report of the Crawford W. Long Memorial Committee as recommended by the Reference Committee on motion duly made and seconded.

LEGISLATIVE COMMITTEE

JOHN A. BELL, JR., M.D., *Chairman*

EUSTACE A. ALLEN, M.D., *Vice-Chairman*

As was the case last year, your Committee on Legislation has been vitally concerned with the activities of Congress in the medical care field. This interest, of course, is generated by the genuine concern of the medical profession regarding "Forand type" legislation, and the recognized need of some of our older citizens for medical care at public expense.

Your Committee was very active in the Congressional consideration of legislation which has since become known as the Kerr-Mills Law. Congress adopted and President Eisenhower signed this measure into law last fall.

Concurrent with the introduction of President Kennedy's health care of the aged bill during this session of Congress, your Committee sponsored a breakfast at MAG headquarters for representatives of leading statewide trade and civic organizations. This breakfast meeting, designed to enlist support in opposition to this legislation, was a wonderful success and results have been most gratifying. An effective follow-up program was urged among several county societies to stimulate maximum interest and participation in opposition to Social Security financed medical care for the aged legislation. Suggested programs and how to conduct such programs were sent to several county societies by your Committee.

In further reference to this legislation a delegation consisting of Dr. Fred H. Simonton, President-Elect; Dr. John T. Mauldin, Secretary; your Committee Chairman, and Mr. James M. Moffett, Assistant Executive Secretary, had a most beneficial trip to Washington on March 1st at which time Senators Russell and Talmadge

and several members of the House of Representatives were contacted.

State Legislative Activity

On December 7, 1960 MAG hosted the First District Legislative Organizational meeting in Statesboro. Approximately 125 people attended including the Lieutenant Governor and Senate President Pro Tem Carl Sanders as well as many other prominent State governmental officials. Attendance by legislators and wives from the 18 counties of the First District reached the almost 100 per cent mark. This annual affair was in large measure responsible for creating a favorable climate for medicine at the 1961 session of the General Assembly, and it is recommended that this event be continued in the First District and should be extended to the remaining nine districts throughout Georgia.

Of principal concern to your Legislative Committee was the enactment of Senate Bill 32 in the Georgia General Assembly. The enactment of this legislation was the culmination of many long months of conferences with representatives appointed by the Governor in the fall of 1960 to draft legislation on the subject of medical care for the aged. Within the framework of the Kerr-Mills Law your Committee, acting in concert with the Governor's Committee, drafted the legislation now on the statute books of Georgia and known as the "Medical Assistance for the Aged Act." Your Committee on several occasions was called on by the General Assembly to testify in committee in behalf of this and other legislative items.

Several other important legislative measures occupied the time and efforts of your Committee during the 1961 session of the General Assembly. One highly beneficial enactment was the Georgia Professional Association Act which permits two or more professional people to join together in an association for the purpose of obtaining the tax and investment advantages of a corporation. Your Committee was equally active in opposing legislation not in the best interest of better health for Georgia and in opposing legislation inimical to the best interest of the medical profession. Your Committee would like to pay special tribute to Dr. S. U. Braly and Dr. C. L. Ayers representing the 36th and 37th Senatorial Districts of Georgia, respectively. Their devotion to good government and good medical legislation has been immeasurable. In addition, special recognition is in order for the fine work done by and the invaluable assistance rendered by MAG legal counsel.

Other Legislative Activity

During the past year the "legislative keyman" system was extended to include the appointment of a physician to serve as keyman in each of the county societies. The extension of this system was pursuant to a recommendation made by the Legislative Committee at the 1960 Annual Session. While the keyman system has not achieved all that was hoped of it, it does provide the machinery by which two-way communications may be kept open between the political leadership of the county and district and the members of the county medical society and the Medical Association. It is recommended that this system be strengthened by

adoption of a policy which will permit keymen and other physicians to become personally acquainted with their representatives in the General Assembly and their representatives in Congress.

In the interest of improved communications and in an effort to better present the views of the medical profession on the matter of health care for the aging, your Committee distributed to the President of each county medical society wherein a daily newspaper is published, an informational packet which in turn was placed in the hands of editors of these newspapers. This packet prepared by the AMA was especially designed to provide editorial writers with accurate, up to date, factual, and unbiased information in the area of medical care for our senior citizens.

The annual Washington Legislative Luncheon, traditionally held prior to Annual Session, was postponed this year. With the Congressional Easter recess, MAG's Legislative Conference in Macon, and the 1961 Annual Session all falling within a four-week period, your Committee felt that this luncheon should be delayed until after Annual Session. It is contemplated that the Congressional Luncheon will be held during the latter part of May.

In conclusion the Committee would like to recommend that each constituent society as a unit and each physician as an individual give particular attention in the coming months to the proposition that the medical profession has reached the point where a concerted effort must be made if complete freedom from governmental domination and interference is to be maintained. Your Committee recommends increased political participation by both individual physicians and county societies to insure the election of sound men to political office.

REFERENCE COMMITTEE RECOMMENDATION — Dr. Bell and Dr. Allen are commended for their report and this Committee further recommends that each member of the Medical Association of Georgia consider himself a committee of one to improve relations with our legislators and keep closer contact with such representatives when they are in his community.

HOUSE OF DELEGATES ACTION — Adopted the report of the Legislation Committee as recommended by the Reference Committee on motion duly made and seconded.

VETERANS AFFAIRS

LEE HOWARD, JR., M.D., *Chairman*

As you know, the Veterans Affairs Committee has had no meetings during the year.

The material sent to me during the year did not, in my opinion, warrant any committee action. We have had no request for study by a member of the MAG.

For these reasons I do not feel that a Committee Report is indicated, and I have no suggestions to make for future action.

REFERENCE COMMITTEE RECOMMENDATION — This report is approved by Reference Committee No. 1, however, this Reference Committee strongly recommends strengthening the Veterans Affairs Committee and suggests that each county medical society designate a committee on veterans affairs composed of physicians

who will take an active part in veterans affairs and veterans organizations at the local level. It is further recommended that Council take action to implement this suggestion.

HOUSE OF DELEGATES ACTION—Adopted the report of the Veterans Affairs Committee as recommended by the Reference Committee and the additional recommendation of the Reference Committee on motion duly made and seconded.

REHABILITATION

ROBERT L. BENNETT, M.D., *Chairman*

The Committee on Rehabilitation feels that it can be of greatest service to the physicians of Georgia by compiling a Directory of Rehabilitation Resources in our State. Upon completion, this pamphlet would be distributed not only to the physicians of Georgia, but to all agencies, services, and individuals interested in rehabilitation of the physically handicapped throughout the State. It was the initial attempt of this Committee to have its members gather the data, send the data to the Chairman for sorting, and eventual publication. This proved to be completely impractical as it was found that the State of Georgia had far more resources to serve disabled persons than had been originally visualized. To be of real value, the pamphlet must be far more extensive than we had planned. We further found that there was an amazing sparsity of information about rehabilitation resources in Georgia. It simply was not available to our Committee members without survey far beyond the time they could possibly be expected to spend on this project.

We also found that other groups were interested in compiling this kind of information, but had done very little about it, apparently for the same reason that the Committee on Rehabilitation found it such a difficult task.

Out of all this grew the realization that to develop an adequate and informative listing and description of rehabilitation resources in Georgia would require financial and personnel resources of many groups. However, the job has been made easier because the Office of Vocational Rehabilitation of the Department of Health, Education, and Welfare has just issued a paper titled "Procedures Utilized in the Development of the Directory of Rehabilitation Resources in Minnesota."

It is now proposed that the Medical Association of Georgia, through the Committee on Rehabilitation, act as coordinator and one of the sponsors of the project to prepare the pamphlet on Rehabilitation Resources in Georgia. The attempt will be made by the several sponsors to obtain sufficient grant funds, to hire personnel necessary to gather the data, put it in proper format, and eventually publish and distribute this information.

REFERENCE COMMITTEE RECOMMENDATION—Reference Committee No. 1 feels that this Committee has had an overwhelming job and approves their report with the further recommendation that Council give this committee the necessary financial and moral support to help in compiling and disseminating information to the physicians of Georgia and to the general public, concerning the availability of these various facilities and their utilization by the physician.

HOUSE OF DELEGATES ACTION—Adopted the report of the Rehabilitation Committee as recommended by the Reference Committee and the additional recommendation of the Reference Committee on motion duly made and seconded.

VWF LIAISON

CHARLES R. ANDREWS, M.D., *Chairman*

At the present reporting it has been impossible to get the groups of the Medical Association of Georgia and the Georgia VFW together although several attempts have been made to do so. While it is not felt that this Committee is of the utmost importance, it has has great potentials of being worthwhile, and it is recommended that the Committee be continued.

REFERENCE COMMITTEE RECOMMENDATION—This report is approved. Reference Committee No. 1 recommends that consideration be given to combining this committee with the Veterans Affairs Committee and that the expanding committee be much more active in the future in all aspects on the subjects concerned.

HOUSE OF DELEGATES ACTION—Adopted the report of the Veterans of Foreign Wars Liaison Committee as recommended by the Reference Committee on motion duly made and seconded.

Supplementary Report of the President No. A

HEALTH CARE OF THE AGING

MILFORD B. HATCHER, M.D., *President*

Your Officers and Council supported and endorsed the Kerr-Mills Bill. I feel it would be fitting for the entire House of Delegates to endorse the action of your Council and request it (Kerr-Mills Bill) be implemented as fully and expeditiously as feasible, not only in Georgia, but in the entire country.

There has been introduced in Congress a bill (HR 4222), designated as the King bill, which your Officers feel is a foot-in-the-door toward the socialization of medicine and feel that it would be fitting if this House of Delegates would pass a Resolution stating such, not only for this bill, but any similar type of legislation.

It is my feeling that we should get State implementation of the Kerr-Mills Bill in our state as it is of paramount importance. It is felt that we should not lose sight of the Health Indigent Care Bill, which was passed several years ago and has never been implemented. After the Kerr-Mills Bill is implemented and working satisfactorily, then I feel that the HIC is certainly a very worthwhile bill, which fits in with the Kerr-Mills Bill, and I also recommend that it be implemented. It is felt that this is certainly a counter proposal against federal compulsory health insurance.

During the past we have shown some complacency toward Civil Defense in case this country should be bombed or attacked by outside enemies. It is the feeling of your President that our civilian defenses and measures for emergency treatment of disaster victims should be re-evaluated and our position of cooperation be re-affirmed, for it now appears as though a disastrous attack from outside enemies is more of a reality than it

has ever been in the past history of this country. country,

REFERENCE COMMITTEE RECOMMENDATION — Dr. Hatcher's report is approved and should be implemented by the following resolutions:

(1) Resolved, that the House of Delegates of the Medical Association of Georgia strongly urges the State of Georgia to allocate funds for immediate implementation of health care of the aged under the Kerr-Mills Bill, and

Be It Further Resolved, that a copy of this resolution be sent to the Governor of our state.

(2) Be It Resolved, that the House of Delegates of the Medical Association of Georgia go on record as being in strong opposition to the King-Anderson bill and any legislation tying health care of the aged to Social Security, and

Be It Further Resolved, that the House of Delegates of the Medical Association of Georgia go on record as supporting the Kerr-Mills Law because, in the American way, it cares for those who are most needy, and

Be It Further Resolved, that the Secretary of the Medical Association of Georgia be instructed to forward copies of this resolution to the Georgia Congressional Delegation and appropriate Congressional Committees.

The last paragraph of this Supplementary Report No. A concerning complacency toward civil defense was referred to Reference Committee No. 4 for their consideration with the Medical Civil Preparedness report.

HOUSE OF DELEGATES ACTION — Adopted the Supplementary Report of the President No. A: Health Care of Aging with the additional two resolutions recommended by the Reference Committee and with the deletion of the last paragraph of Supplementary Report No. A concerning civil defense, which we referred to Reference Committee No. 4 for their consideration on motion duly made and seconded.

Resolution No. 1

AMA SUPPORT BY INDIVIDUAL PHYSICIANS

COWETA COUNTY MEDICAL SOCIETY

Inasmuch as numerous efforts by certain political opponents of the American Medical Association have been made in recent months in the press and other media to discredit the American Medical Association by insinuating (or by stating outright) that the Association does not have the support of the majority of practicing physicians in this country and does not represent the will of the majority of practicing physicians in this country,

Be it resolved, that the various county medical societies of the Medical Association of Georgia go on public record (by paid advertisement, if necessary) as stating emphatically that the American Medical Association does, indeed, represent their will and desire and that the present leadership of the American Medical Association enjoys the full confidence and support of the entire membership of the Medical Association of Georgia.

Be it further resolved, that other state medical associations be encouraged to do likewise in an effort to squelch, at least, this bit of misinformation currently circulating through the mass media.

REFERENCE COMMITTEE RECOMMENDATION — This Resolution is approved with the recommendation that the Secretary of the Medical Association of Georgia forward copies of this Resolution to all other state medical societies and to all county medical society secretaries of this state for reading before their individual societies. Campanent medical societies are urged to pass similar resolutions and forward them to their community congressional representatives.

HOUSE OF DELEGATES ACTION — Adopted Resolution No. 1: AMA Support by Individual Physicians, as recommended by the Reference Committee and the additional recommendation of the Reference Committee on motion duly made and seconded.

Resolution No. 2

"GOOD SAMARITAN LAWS" LEGISLATION

SPALDING COUNTY MEDICAL SOCIETY

Whereas, it has come to the attention of the members of the Spalding County Medical Society that through certain decisions of the courts, persons who have rendered first aid to an injured party in an emergency have been held to be liable to the injured party for damages;

And whereas, in the event of a national emergency or common disaster this would greatly deter the administration of first aid to the injured, both by members of the medical profession and others who might be trained to administer first aid to an injured person;

And whereas, because of the decisions of the courts, other states have, through their General Assembly, enacted laws known generally as "Good Samaritan Laws";

Now, therefore, be it resolved by the Spalding County Medical Society, that we go on record as urging the Medical Association of Georgia to adopt a resolution asking the next session of the Georgia General Assembly to enact laws commonly known as "Good Samaritan Laws" in order to protect any person who, in an emergency, renders first aid to an injured person without any charge therefor.

Be it further resolved, that a copy of this Resolution be spread upon the minutes of this meeting and a copy thereof sent to the Secretary of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION — Approved as amended:

Whereas, it has come to the attention of the members of the Medical Association of Georgia that through certain decisions of the court, persons who have rendered first aid to an injured party in an emergency have been held liable to the injured party for damages, and

Whereas, in the event of a national emergency or common disaster this would greatly deter the administration of first aid to the injured, both by members of the medical profession and others who might be trained to administer first aid to an injured person, and

Whereas, because of the decisions of the courts, other states have, through their General Assembly, enacted laws generally known as "Good Samaritan Laws,"

Now, therefore, be it resolved, that the House of Delegates of MAG goes on record to ask the next session of the Georgia General Assembly to enact laws commonly known as "Good Samaritan Laws" in order to protect any person, who in an emergency, renders first aid to an injured person without any charge therefor.

HOUSE OF DELEGATES ACTION — Adopted Resolution No. 2: "Good Samaritan Laws" Legislation as amended by the Reference Committee on motion duly made and seconded.

Resolution No. 4

MARRIAGE LAWS LEGISLATION

MUSCOGEE COUNTY MEDICAL SOCIETY

Whereas, the integrity of the civilization of tomorrow depends upon the type individual produced in this generation; and

Whereas, the type individuals produced depends upon

the type families from whence they spring; and

Whereas, the number of youthful, immature, teen-age marriages, juvenile crime and family break-down are on the increase, and

Whereas, it has been proven that these youthful teen-age marriages make poor family units, and are fraught with emotional distress, anxiety, and separation, and

Whereas, we as members of the medical profession feel it is our responsibility as physicians as well as parents to see that proper families are developed in the future; and

Whereas, in studying the Marriage Laws of the State of Georgia we realize that certain areas need strengthening, fully understanding that this is not the entire answer to this problem;

Therefore, be it resolved, that the Medical Association of Georgia endorse and support the following proposals in the Marriage Laws of the State of Georgia which will be introduced in the 1962 Georgia Legislature:

1. Raise the minimum age of consent to 18 years for the male and 16 years for the female, instead of 17 years for the male and 14 for the female. There is a proviso in the bill that in the case of a pregnancy under age then judgment will be left in the hands of the Judge of the Superior Court or Judge of the Juvenile Court if one is present in that district.

2. There shall be a compulsory five-day waiting period for all marriages.

3. A birth certificate shall accompany all applications for a marriage license.

4. It shall be a misdemeanor for any Ordinary to violate any of the existing marriage laws.

REFERENCE COMMITTEE RECOMMENDATION — This is approved as amended:

Therefore, be it resolved, that the Medical Association of Georgia endorse and support the following proposals concerning the marriage laws of the State of Georgia when considered by the 1962 Georgia General Assembly, and

Be it further resolved, that the House of Delegates request that the Auxiliary to the Medical Association of Georgia consider the advisability of adopting this as a project for their organization to bring this matter to the public attention at the "grass roots" level, and

Be it further resolved, that copies of this resolution be forwarded to the Georgia Bar Association, Parent Teacher Associations, and other appropriate organizations.

HOUSE OF DELEGATES ACTION — Adopted Resolution No. 4: Marriage Laws Legislation, as amended by the Reference Committee on motion duly made and seconded.

It was moved by the Chairman of Reference Committee No. 1, Jule C. Neal, Macon, Chairman, and duly seconded that the Report of Reference Committee No. 1 be approved as a whole and it was so ordered.

Report of Reference Committee No. 2

J. Bothwell Traylor, M.D., Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendations and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 2 met at 8:00 A.M. in Room 1011, Biltmore Hotel, Atlanta, Georgia, May

8, 1961. The following members of the Committee were present: J. Bothwell Traylor, Athens, Chairman; Tully T. Blalock, Atlanta, Vice Chairman; Don Schmidt, Cedartown, Secretary; Jack Waters, Augusta; James H. Jenkins, Rome; Van B. Bennett, Valdosta, and A. G. LeRoy, Thomson.

SECRETARY

JOHN T. MAULDIN, M.D., Atlanta

The Secretary's position has proven to be a very busy one in 1960 and has consisted primarily of coordinating the activities of the Medical Association of Georgia. The majority of my time has been spent in dealing with State and National legislative activities. I have served as Chairman of the Commission on Aging and attended the Georgia Conference on Aging and the White House Conference on Aging. The work with the Governor's Study Committee to draft enabling legislation for the Kerr-Mills Bill proved very interesting and time-consuming before and during the State Legislature. I have been fortunate in being able to assist with the liaison with our congressmen and senators in Washington. My impression is that those who preceded the present representatives did an excellent job in that we were always received with courtesy and our side of the story listened to with respect.

I have made several trips to both county and district medical societies, civic groups, and related organizations, as MAG representative. The principal organizations worked with were the Hospital Association, nursing educators, pharmacists, Nursing Home Association, Health Department, Welfare Department, dentists, and health insurance representatives.

I have attended the Council and Executive Committee meetings of the Medical Association of Georgia.

Hospital Medical Council

During the past year I have had the honor of serving as Chairman of the Hospital Medical Council. This Council was established to afford recognition of the smaller hospitals in Georgia who are doing a good job. The Council has approved four hospitals, failed to approve two, and is in the process of inspecting two additional hospitals. Since this Council deals with only hospitals of 25 beds or less, this represents a remarkable progress because of the smaller number of such hospitals.

Headquarters Office Responsibility

The Secretary has coordinated the administrative problems of the Headquarters office, advised on administrative policy and methods of office operation, has handled the correspondence on matters related to medical policy not within the jurisdiction of other officers or committees, and has advised the staff on other pertinent matters. The Headquarters staff has functioned well, has been well coordinated, and most cooperative.

Headquarters Building

The foresight of the previous Secretary and his Council in choosing and establishing the Medical As-

sociation of Georgia in its new building has proven more than justified. This building has been used as a meeting facility approximately twice a week by MAG and allied organizations, and it has worked well. On occasion as many as three committee meetings have been held simultaneously without conflict. It has been possible, with the help of a caterer, to serve meals when the occasion demanded.

The office space has proven adequate, pleasant, and efficient. The building as a whole has provided a center for MAG's statewide activities and has been an adequate background for the enhancement of the association's sphere of influence.

Medicare

The Medicare program in Georgia operates under a contract negotiated between the Department of the Army and the Medical Association of Georgia. The actual administration of the program is handled in the MAG Headquarters Building in Atlanta by a staff of two full-time and one part-time personnel. The Council designated me to act as coordinator in those questions not usually covered by the Review Board. Two changes in contract were brought about by the recommendation of an interested physician and the policy established of having physicians with questions contact the State Review Board Chairman, who is to arrange a meeting with the Local Review Board physicians, if necessary, in resolving problems and questions. The Medicare program in Georgia is now in its fifth year of operation. In the calendar year of 1960 the total amount paid to Georgia physicians was approximately \$650,000. Approximately 7,800 claims were paid during this year with an average payment of \$83.33 per claim. Over 2,000 individuals participated in the Medicare program during the past year. I wish to point out that approximately 30 per cent of all claims reviewed in the Medicare payment office were returned to physicians for lack of proper information. It would simplify the work a great deal if the doctors would instruct their secretaries to properly complete these forms.

MAG Membership

MAG is continuing its growth with an increase of 43 members during the past year. One of our major delinquencies is that there are a number of doctors in Atlanta who are neither members of MAG or AMA.

The membership figures for 1960 are:

Active	2,516
Active Dues Exempt	356
Associate	16
Honorary	0
Service Members	42
TOTAL	2,930

Summary

In summary the recommendation that I have from my first year's activity as MAG Secretary, I have discussed with Council and the proper committees for their consideration. In fulfilling the duties of the office of Secretary I have not encountered a single individual who was not willing to resolve his problems by a frank and open discussion, thus attaining mutual under-

standing. I, thereby, am privileged to express my appreciation to the membership for their understanding and cooperation.

REFERENCE COMMITTEE RECOMMENDATION — This report was approved and commended. The Secretary was commended for his services as Chairman of the Governor's Commission on Aging.

HOUSE OF DELEGATES ACTION — Adopted the report of the Secretary as recommended by the Reference Committee on motion duly made and seconded.

TREASURER

C. RAYMOND ARP, M.D., *Atlanta*

The auditors of The Medical Association of Georgia, Ernst and Ernst of Atlanta, have prepared an audit and the report for the calendar year ending December 31, 1960 is attached.

We have again had a very active year. The committees have been more active than ever before and this increases our expenses. Of course, this is money well-spent. If our committees were not active, we would have very little need for our organization. It is good to see that we have ended up the year with a surplus of about \$9,000.00, after paying all expenses, and paying the planned amount on our Headquarter's Building, plus interest.

There is one change in our financial records and reporting for the year 1961 that should be helpful. The Treasurer attends all monthly meetings of the Council and of the Executive Committee. He gives, each time, a detailed monthly financial statement showing the budget of the various departments and committees; the income received to date, and the amount of money spent by each of the departments and committees up to date, and also the amount spent in that particular month. This will give an up-to-the-minute picture of our financial condition, compared with the budget for the year. The budget is set up by the Finance Committee of the Council and is approved by the Council. The money is never spent without approval of the Council.

I want to thank Thelma Franklin, especially, and the Central Staff of our Association for the efficient carrying out of their duties and the excellent co-operation given me.

ERNST & ERNST

FIRST NATIONAL BANK BUILDING

ATLANTA 3, GA.

ACCOUNTANTS AUDITORS
MANAGEMENT SERVICES

OFFICES IN PRINCIPAL CITIES
ASSOCIATES IN FOREIGN COUNTRIES

Chairman of the Council
The Medical Association of Georgia
Atlanta, Georgia

We have examined the statement of assets and liabilities of The Medical Association of Georgia funds at December 31, 1960 and the related statements of income and expenses and equities for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying statement of assets and liabilities - by funds and the statements of income and expenses - by funds and fund equities present fairly the financial position of The Medical Association of Georgia at December 31, 1960, and the results of its operations for the year then ended in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Ernst & Ernst

Certified Public Accountants

Atlanta, Georgia
March 1, 1961

STATEMENT OF ASSETS AND LIABILITIES—BY FUNDS

The Medical Association of Georgia

Year Ended December 31, 1960

ASSETS

GENERAL FUND

Cash			\$ 1,935.50
United States government securities — at cost or redemption prices (approximately equal to market)			12,840.00
Accounts receivable:			
Due from United States government:			
Medicare program:			
Excess of claim expenses over professional claim fees received		\$ 4,942.78	
Advertisers of The Journal	\$7,984.74		
Other accounts	<u>425.00</u>	<u>8,409.74</u>	13,352.52
Property and equipment—on the basis of cost:			
Land—mortgaged			\$80,000.00
Buildings—mortgaged		\$110,954.72	
Furniture and equipment		<u>22,778.42</u>	
		\$133,733.14	
Less allowances for depreciation		<u>13,435.63</u>	<u>120,297.51</u>
			<u>\$228,425.53</u>

ABNER W. CALHOUN LECTURESHIP FUND

Cash	\$ 163.21		
Corporation stocks—at cost (quoted market prices \$5,217.38)		<u>6,101.85</u>	6,265.06

MEDICARE FUND—DEPARTMENT OF THE ARMY

Cash	\$ 61,577.83		
Due from United States government:			
Service fees paid to physicians and dentists		<u>23,422.17</u>	<u>85,000.00</u>
			<u>\$319,690.59</u>

LIABILITIES AND EQUITIES

GENERAL FUND

Liabilities:			
Note payable to insurance company, \$4,000.00 installment, with interest at 5%, due on January 1, each year — secured by loan deed on land and building		\$ 36,000.00	
Membership dues collected in advance		<u>451.00</u>	\$ 36,451.00
Fund equity:			
Restricted for regular operating purposes	\$ 20,000.00		
Restricted for lecture expenses		395.04	
Unrestricted		<u>171,579.49</u>	<u>191,974.53</u>
			<u>\$228,425.53</u>

ABNER W. CALHOUN LECTURESHIP FUND

Fund equity			6,265.06
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MEDICARE FUND—DEPARTMENT OF THE ARMY

Advance from United States government			<u>85,000.00</u>
			<u>\$319,690.59</u>

STATEMENT OF FUND EQUITIES

The Medical Association of Georgia
Year Ended December 31, 1960

	Balance Jan. 1, 1960	Income in Excess of Expenses	Fund Transfers	Balance Dec. 31, 1960
GENERAL FUND				
Restricted for operating purposes	\$ 20,000.00	\$ -0-	\$ -0-	\$ 20,000.00
Restricted for lecture expenses—Note	130.07	-0-	264.97	395.04
Unrestricted—Note	158,562.97	13,016.52	-0-	171,579.49
	<u>\$178,693.04</u>	<u>\$ 13,016.52</u>	<u>\$ 264.97</u>	<u>\$191,974.53</u>
ABNER W. CALHOUN LECTURESHIP FUND	6,265.06	264.97	264.97*	6,265.06
TOTAL	<u>\$184,958.10</u>	<u>\$ 13,281.49</u>	<u>-0-</u>	<u>\$198,239.59</u>

*Indicates red figures.

Note—Fund balances at January 1, 1960, consisting principally of amounts previously designated as Building Fund, have been reclassified to the General Fund to conform to the classifications used for the year ended December 31, 1960.

STATEMENT OF INCOME AND EXPENSES—BY FUNDS

The Medical Association of Georgia
Year Ended December 31, 1960

	General Fund	Abner W. Calhoun Lectureship Fund
INCOME		
Medical Association of Georgia dues	\$100,192.50	\$ -0-
Advertising — The Journal	51,919.04	-0-
Subscriptions — The Journal (non-members)	735.68	-0-
Exhibitors' fee — 1960 annual meeting	9,100.00	-0-
Interest — United States government securities	342.50	-0-
Dividends — corporate stocks	-0-	278.92
American Medical Association refund	595.38	-0-
Miscellaneous	150.53	-0-
TOTAL INCOME	<u>\$163,035.63</u>	<u>\$ 278.92</u>
EXPENSES		
Fixed allotments	8,551.48	\$ -0-
Association office	63,488.41	-0-
Medical Association of Georgia committees	15,360.45	-0-
1960 Annual Session	11,694.61	-0-
The Journal	48,116.75	-0-
Trustee's fees	-0-	13.95
Lectureship expenses	-0-	-0-
Furniture and fixtures abandoned	2,807.41	-0-
TOTAL EXPENSES	<u>\$150,019.11</u>	<u>\$ 13.95</u>
EXCESS OF INCOME OVER EXPENSES	<u>\$ 13,016.52</u>	<u>\$ 264.97</u>

REFERENCE COMMITTEE RECOMMENDATION — The report of the Treasurer was approved. The financial form for recording was approved and commended.

HOUSE OF DELEGATES ACTION — Adopted the report of the Treasurer as recommended by the Reference Committee on motion duly made and seconded.

SPEAKER, HOUSE OF DELEGATES

THOMAS W. GOODWIN, M.D., *Augusta*

As in the past I wish to again express my appreciation to the members of the Association House of Delegates for their prompt and orderly conduct as the representatives of the county medical societies. Their complete cooperation at all times has allowed the business of the House to proceed in a democratic and efficient manner.

As you know, some controversial matters have been presented to this House from time to time. Your wise and cool judgment has prevailed to the credit of our Association. Those delegates who serve so diligently on House Reference Committees deserve praise.

My single recommendation addresses itself to those county medical societies *not* represented by their delegates. To this end, I recommend that the Association use its full persuasive power to gain full participation by each society's duly elected delegates.

I also wish to commend the Vice-Speaker of the House, Dr. J. Frank Walker. He has been diligent in carrying out his duties and in his attendance at Council meetings.

REFERENCE COMMITTEE RECOMMENDATION — This report was approved and commended. The Committee was concerned with the lack of interest shown by some county societies in their not being represented by delegates in the House. It was recommended that this problem be referred to Council for additional study.

HOUSE OF DELEGATES ACTION — Adopted the report of the Speaker of the House of Delegates as recommended by the Reference Committee on motion duly made and seconded.

VICE-SPEAKER, HOUSE OF DELEGATES

J. FRANK WALKER, M.D., *Atlanta*

The House of Delegates, the legislative branch of the Medical Association of Georgia, constitutes a democratic policy-making body, the success of which depends on individual initiative and active participation.

It is a matter of concern that many delegates, who faithfully attend the initial session of the House, fail to appear at the final meeting. They listen to the presentations of resolutions and reports, but fail to exercise the vote several days later.

It is a matter of concern that some of the smaller societies do not avail themselves of representation in the House. Every effort should be made to elect competent and industrious delegates who will adequately represent each society at meetings of the House of Delegates.

The Vice-Speaker, who, between annual sessions, attends meetings of the MAG Council, is impressed with the industry, sacrifice, and intelligent activity of the councilors, who act along the lines of policy already established by the House.

REFERENCE COMMITTEE RECOMMENDATION — This report was approved.

HOUSE OF DELEGATES ACTION — Adopted the report of the Vice Speaker of the House of Delegates as recommended by the Reference Committee on motion duly made and seconded.

INDUSTRIAL HEALTH

T. A. PETERSON, M.D., *Chairman*

As Chairman of the Industrial Health Committee of the Medical Association of Georgia, it has been my pleasure to attend the Industrial Health Congress of the American Medical Association, held in Charlotte, North Carolina in October of 1960.

At this meeting there were many interesting facets relative to the growing importance of Industrial Health needs, in many of our areas, particularly in the Southern states, as it is so very obvious that industry is rapidly moving into our communities. It is particularly important that the doctors of the State of Georgia be more cognizant of the increased industrial type of medical practice and to assume that these patients would be handled and treated as ordinary private patients. That is very essential because it is in that area of relationship that the handling of industrial patients is more satisfactorily performed. It was also a very satisfactory occasion to meet with the head of the Workman's Compensation Board of the State of Georgia, Mr. Roscoe Lowry, to discuss the matter of fee schedules, and also to discuss with him the need of Medical Review Board, to assist the Workman's Compensation Board in more properly evaluating certain treatments and conditions relative to medical problems that come before them. This meeting with Mr. Lowry was very pleasant and it is the impression of the Chairman that a satisfactory, improved schedule of fees and perhaps an improvement in the overall payment for compensation cases could be elevated.

REFERENCE COMMITTEE RECOMMENDATION — This report was approved.

HOUSE OF DELEGATES ACTION — Adopted the report of the Industrial Health Committee as recommended by the Reference Committee.

INSURANCE AND ECONOMICS

DAVID R. THOMAS, JR., M.D., *Chairman*

The work of this Committee has been broadened more during the year with studies that are in progress concerning the economics of the profession. The insurance for the members of the Medical Association of Georgia and of the public has been studied and the ground work is being laid for further study and development in the overall field of medical insurance and the economics of the profession and the public. In fields where special studies of such magnitude have developed, it has been the policy of this Committee, as in the past, to recommend the formation of other committees to handle these studies, in coordination with the Insurance and Economics program. The close liaison and assistance of Mr. Krueger, the Headquarters Staff, and our

legal counsel, is acknowledged and is very necessary for the proper function of this Committee.

The Georgia Plan

Dr. John Elliott, with the assistance of Mr. H. B. Coolidge has continued to handle the settlement of unlisted procedures and to act as arbitrators in the claims of insurance companies under the Georgia Plan. Their knowledge and unfailing service continues to be invaluable in carrying out this program. With the increased income of many segments of the population affected by the Georgia Plan, studies of the limits involved will demand further review and possible adjustment.

Group Insurance Plan—Life Insurance Company of Georgia

The Life Insurance Company of Georgia has given a report of the participation in the group plans as of February 8, 1961, which totals 1,191 participating. Of this number 478 are participating in the entire plan, 886 have life insurance, 862 have disability income, and 721 have the catastrophic hospital coverage.

As you know the group coverage started November 15, 1959, and there were eight deaths as of December 31, 1960, with a total of \$71,500.00 being paid in incurred claims by the Life Insurance Company of Georgia. This represents a very high loss-ratio which might be expected for the first year of such coverage without proof of insurability.

The major hospital or catastrophic type of hospitalization insurance represents the most unsatisfactory loss-ratio, though we are not in a position as yet to fully evaluate the experience. The Life Insurance Company of Georgia feels that it is necessary to increase the premiums on this coverage, though neither the Committee, nor the Insurance Company knows what the experience will be after two full years of coverage. This will have to be studied in detail with our insurance carrier probably in August 1961.

The Life Insurance Company of Georgia has agreed to offer major hospital coverage for the widows and their dependents of members of MAG. The medical auxiliaries of each component society have been asked that Mr. Krueger be furnished with a list of all such widows, in order that this coverage might be offered to them on the same basis and probably with a slightly less premium than was offered members and dependents. This list has not been completed and action by the insurance company has so far been deferred pending a complete list.

The experience with Accidental Death and Disability and Weekly Income Group coverage was more than satisfactory, though this represents a relatively minor portion of the premiums paid.

The combined incurred claims, plus reserves set aside (the exact amount being roughly estimated but not furnished the Committee) of all insurance with a loss-ratio of 95.28 per cent (which includes reserves set aside). It is understood that in group insurance the experience in handling the insurance will determine the premiums and this will be adjusted, either up or down, so that the members of the Medical Association of Georgia and their dependents will be covered at the most economical premium possible. Questions on the opera-

tion of this are invited and requested, and if there is anything that can be done in assisting the members of MAG, the Insurance Committee is anxious to be of such assistance as is possible.

The Committee has found the representatives of the Life Insurance Company of Georgia to be most cooperative. Close cooperation and a mutual understanding is necessary between your Committee and the Life Insurance Company of Georgia. Mr. John M. Bragg, Vice President and Actuary and Mr. Edward D. Lord, Vice President and Group Manager have been most cooperative and are believed to have an excellent understanding of our needs. An analysis of the experience is essential and will be followed with subsequent reports to Council. It is felt to date that for the first year of operation the experience was not unanticipated.

National Congress on Prepaid Health Insurance

The Chairman attended this meeting in Chicago on May 13th and 14th, 1960 and much information was disseminated on prepaid health insurance. Dr. J. Lafe Ludwig, Chairman of the AMA Council of Medical Service, presided and there was a meeting of members of the American Medical Association, representatives of the Federal Government, the private insurance industry, Blue Cross-Blue Shield, Private Group Practice Plans, "Self Insured" Union Plans, foundations for medical care, and physicians from throughout the country representing the state medical associations. We were given a background for the Congress and then went into a very enlightening program with free discussion and apparently a very fine spirit of give and take between the different representatives was experienced. Many facets were covered by panels of very well qualified men. The conference was summarized at its conclusion by Professor Walter J. McNerney, Director, Program of Hospital Administration, School of Business Administration, University of Michigan, Ann Arbor, Michigan. Professor McNerney very ably summarized the conference and felt that there had been no discernible attempt made to exclude opposing points of view, nor to duck the key issues. He acknowledged the fact that this Congress was an extension of the American Medical Association program and that it stood as a sure sign that organized medicine is taking its economic responsibility seriously. It is apparent that such groups should continue to meet and discuss issues frankly. Active debates and forums for the advancement of the Economics of Medical Care must be disseminated to physicians and their participation solicited. The doctors generally need to know more about operation problems, prepayments and insurance company interest, and interest developed in the operation and social engineering problems is the responsibility of the profession.

AMA Relative-Value Schedule Meeting

A very informative meeting of relative value schedule of fees sponsored by the American Medical Association was held in Atlanta, November 5, 1960, and much information was disseminated. As a result of this meeting, Council has appointed a Committee of MAG that might have some very far-reaching effect on the economics of the practice of medicine in the future. It was felt that this Committee should be set up as a

separate committee, as it is probable that much work will be necessary, though a close liaison with the Insurance and Economics Committee is anticipated.

Retirement Programs

Many proposals have been received during the past year, adding to the information being accumulated, in preparation of the passage of HR 10, or an amended version of the original Keogh Bill. It is the feeling of the Committee that much saving might be anticipated, though the ultimate revisions and passage of the bill is uncertain.

At a meeting of the Committee in February it was decided to take the offensive in accumulating some information and ask the members of the Medical Association of Georgia to cooperate in obtaining factual information, and we were able to obtain the assistance of the Trust Department of the Georgia Railroad Bank and Trust Company, which is gratefully acknowledged in calculating the result of the data requested. If obtained, this will be reported as an addendum at the Atlanta meeting.

The ever-expanding work of the Committee is accomplished only through the active participation of the members of the Committee. The actual meetings of the Committee are held to a minimum, though conferences between members and the dissemination of information is essential. The interest manifest by the members of the Committee is gratefully acknowledged and appreciated by the Chairman.

Association of Georgia should forward to each physician in Georgia a review of participating insurance companies in the Georgia Plan and the services covered and limits of the plan on a service basis.

HOUSE OF DELEGATES ACTION—Adopted the report of the Insurance and Economics Committee as recommended by the Reference Committee on motion duly made and seconded.

PUBLIC SERVICE

JOHN P. HEARD, M.D., *Chairman*

During the past year the Committee again sponsored an Indoctrination Conference for the newly-elected county society officers. A special feature of the 1961 Conference was the presentation of a Secretary's Handbook, with completely new and up-to-date forms for conducting all society business. It was felt that this would streamline the secretary's job and allow for greater contact between the local society and the MAG office.

A survey showed that only 90 per cent of MAG members are also members of AMA. It was felt that with the tremendous help the AMA is offering both local and the state societies that we should have 100 per cent participation in AMA. A survey of the societies and reasons for members not joining AMA has been conducted and a program to encourage AMA membership has begun. It is requested that the House of Delegates urge local societies to strive for 100 per cent AMA membership.

Continued interest in highway safety has been carried on.

The Vice-Chairman of the Committee attended the AMA Public Relations Conference in August, 1960.

A special medical supplement in the *Atlanta Journal-Constitution* is planned on the day the Annual Session opens in Atlanta, May 7.

Internal public relations between MAG and the local society have been encouraged. A number of programs have been put on at the society level by the Committee.

The Chairman feels that the Committee has had a successful year, but believes that public relation activities are hampered by the lack of time physicians can give and the lack of time which can be devoted to public relations by the MAG staff.

Communication with the local society is one of the biggest problems of the MAG Office. Plans are under way to publish a Society Newsletter, a special Public Relations Section, and incorporate it in the *Journal of MAG* each month.

Legislation has naturally taken priority, and consumed a tremendous amount of time of the office staff, and will continue to do so. However, a parallel to the fight against Forand-type legislation is good public relations.

In order for an active public relations program to be formulated and placed before the people of Georgia, it is felt that a society as large as ours needs one additional staff member in the home office devoting his entire time to public relations. The cost of this would be considerable, however, the urgency of good public relations at this critical time cannot be over-estimated.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved. The recommendation for an additional employee for the state office was referred to Council for further study. The staff is encouraged to give increased activity in the field of public relations in order to give the true doctor image to the people.

HOUSE OF DELEGATES ACTION—Adopted the report of the Public Service Committee as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 3

BLUE CROSS PROFESSIONAL SERVICES COVERAGE

THOMAS J. ANDERSON, JR., M.D. DELEGATE,

FULTON COUNTY MEDICAL SOCIETY

Whereas, the Blue Cross Plans of Atlanta and Columbus and some other hospitalization plans provide payment for certain professional services as a benefit in their policies; and

Whereas, Blue Cross and Hospital Insurance plans provide payment for authorized hospital services only and should not provide coverage for professional services of the practice of medicine; and

Whereas, there are indications in at least one other state that Blue Cross plans have expanded their sphere of insurance coverage to include out-patient care in certain hospital departments, further encouraging the unauthorized practice of medicine by hospitals; and

Whereas, local Blue Cross groups were recently consolidated into a national Blue Cross Association with

strong backing from the American Hospital Association; and

Whereas, under this consolidation, the insurance program of one Blue Cross Plan offering out-patient coverage may become attractive to other local plans and even be extended to cover specialties and phases of medicine not now included; and

Whereas, the House of Delegates of the AMA in December, 1960, by resolution number 27, adopted a report similar to this resolution and urged constituent associations to take appropriate action;

Therefore, be it resolved, that the Medical Association of Georgia act immediately to effect transfer of professional services from Blue Cross and other hospitalization plans to Blue Shield or that section of other insurance plans providing for professional services, whenever such situations exist; and

Be it further resolved, that if any further out-patient hospital benefits involving professional services are provided by the Blue plans, the Medical Association of Georgia be on record as favoring these be included under Blue Shield coverage.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved and it was recommended that this resolution be presented to Council for immediate action. Further, it was recommended that a report of the action taken be reported at the next House of Delegates meeting.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 3: Blue Cross Professional Services Coverage, as recommended by the Reference Committee on motion duly made and seconded.

WOMAN'S AUXILIARY ADVISORY

VIRGIL B. WILLIAMS, M.D., *Chairman*

The Committee met with the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia in June, 1960. The Advisory Committee reviewed the proposed activities of the Auxiliary for the coming year.

Since that meeting members of the Advisory Committee have been consulted informally on several occasions and have given advice as indicated. The Advisory Committee has been available for advice at all times.

This committee wishes to express its appreciation for the numerous worth-while projects the Auxiliary has carried out in the interest of the Medical Association of Georgia during the year. We applaud the officers and the entire membership of the Auxiliary for their spirit of cooperation, unselfishness, and valuable aid rendered the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman's Auxiliary Advisory Committee as recommended by the Reference Committee on motion duly made and seconded.

SCHOOL CHILD HEALTH

GRADY E. BLACK, M.D., *Chairman*

The School Child Health Committee has met several times. Attendance has been excellent at our meetings.

Previous and planned projects are as follows:

1. We have supported having health, safety, and physical education in grades seven through 12. We have felt that the physical fitness of our youth is paramount along with mental fitness.
2. We made and circulated the recommendation that each local medical society maintain a list of physicians who are willing to talk to school groups on medical and related subjects.
3. The Committee has requested that a board of physicians be consulted at the time school textbooks on health are selected.
4. We have recommended and supported driver training and school bus safety legislation.
5. Vision and hearing screening has been a continuing project. We have recently requested consultants from the Georgia Society of Ophthalmology and Otolaryngology to act as advisors for our committee when needed. We are considering requesting similar consultants from other specialties.
6. We have promoted immunization on the schedule as recommended by the American Academy of Pediatrics. We also have encouraged the routine tuberculin testing and adequate follow-up on positive cases.
7. The most outstanding project of the year was to sponsor a joint conference on athletic injuries, called Medical Aspects of Sports. Held August 12 and 13 in Columbus, Georgia, the conference was attended by about 150 physicians, coaches, and athletic trainers from Georgia and the Southeast. This conference was most successful thanks to the efforts of Dr. Jack Hughston, who serves on our Committee. Enthusiasm about the conference was so great that we planned to promote and support another such conference this year. Special request for this conference was made by the Physical Education and Health Education Division at the University of Georgia. A conference is planned June 9-10 at Athens. It will differ in that there will be a broadened agenda and include sports other than football.
8. The Committee continues to try to show to parents and school personnel the need for paying special attention to and having special classes for slow learners and certain mentally retarded children in public schools.
9. Some of the members of the School Child Health Committee have attended this past year the following:
 - (1) National Conference on Medical Aspects of Sports in Washington, D. C. in November, 1960.
 - (2) American School Health Association Meeting in San Francisco, California in November, 1960.
 - (3) Two members attended and participated actively in the Eighth National Conference on Physicians and Schools in Chicago, March 9-11, 1961.
10. We are recommending that local medical societies appoint local committees on School Child Health. Their functioning on a local level would better assure improved school child health.
11. The School Child Health Committee will realize

a great loss in John Kiser's leaving the Medical Association of Georgia to work for the American Medical Association. We have appreciated his efforts in the functioning of our Committee and will miss him in school child health work.

REFERENCE COMMITTEE RECOMMENDATION — This report was approved. The Committee is of the opinion that the Medical Association of Georgia should continue its efforts in the functioning of our Committee and will miss him in school child health work.

HOUSE OF DELEGATES ACTION — Adopted the report of the School Child Health Committee as recommended by the Reference Committee on motion duly made and seconded.

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

MRS. W. P. RHYNE, President

It is difficult, in a matter of printed space, to give a full report or picture of the activities of an organization for a year. I trust that this report can give somewhat of a sketch of the happenings of this Auxiliary.

In the beginning, I would like to personally, and in behalf of the Auxiliary, express appreciation and gratitude to the Advisory Committee to the Auxiliary, the members of the Medical Society, and all connected with the Medical Association for the moral support, advice, counsel, and all other ways in which you have so greatly assisted us this year.

National

The President and the delegated number of Delegates attended the National Convention in June in Miami, Fla. In National Auxiliary we have one National Chairman and two Regional Chairmen from our State. In October the President and President-Elect attended National Conference for these officers. The President participated at this Conference by serving as leader in one of the discussion forums.

State

The first duty of the President upon being installed as President was to preside at the Post Conventional Executive Board meeting the last day of Convention. Summer Board Meeting was presided over in June at Radium Springs in Albany, Ga. This was well attended and the Advisory Board from MAG met with us and approved the plans for the year as well as offered suggestions that were helpful to us. The Winter Board Meeting, held in Atlanta at MAG Headquarters in January, was also well attended. A review was made of what had been done in the first half of the year and what was to be accomplished for the remainder of our year.

Community Service

This has been one of our priority projects for this year as well as several years in the past. This is a committee that has functioned well and one that we feel can be most helpful in our communities and to our medical societies. Auxiliaries have given financial aid to

cancer closets as well as needed supplies. Gifts have been given to local hospitals such as magazines, records, and services as Gray Ladies and hostesses. Toys and furniture have been supplied by many auxiliaries to the children's wards in many local hospitals. Some have served by giving volunteer service to indigent cancer patients in their communities. Some work with hospital auxiliaries and clinics. Some auxiliaries decorate and take care of the lounge in their nursing homes. Others have furnished lunches for underprivileged children in schools. In some areas the Auxiliary has made a survey of the nursing home facilities in their areas. Members have participated in work in P.T.A., scouts, church, and civic clubs of all kinds. This has been most rewarding in establishing good public relations between medical and lay citizens, we feel.

Legislation

This has been a very definite part of our work and an activity that has demanded much and a sense of our responsibility along this line. Programs have been planned to keep all members informed with legislation pertinent to the medical profession and to assist in all that concerns them. Members have lent assistance by working with other organizations and helping inform as to our stand. Letters have been written to senators and congressmen of our desire as to the passage of legislation at hand. Many members have worked at polls and similar activities.

American Medical Educational Fund

Since this was adopted by our National and State Auxiliary, we have striven, year by year, to increase our contributions and have succeeded in doing this. At this writing we are doing fine and hope by Convention time that we can report an increase again this year and we believe we will be able to. Our medical schools receive much more than we send in and these contributions are greatly appreciated, from the expressions that we have had from the presidents of our schools in Georgia.

Health Careers

This is another of our committees whose work has broadened greatly in the last few years and this year has been no exception. Encouragement is ever being given by our auxiliaries to interest students in medical fields and to choose them as careers. Gifts to help defray expenses by some auxiliaries have been given. Scholarships have been given by others as well as loan funds set up by some auxiliaries. Many new Health Career Clubs have been formed this year. Programs, literature, and fair exhibits have been used to encourage and interest those who would be good in these fields. Summer jobs in hospitals have been acquired for those who will enter in medical fields. Many volunteer hours have been given by students in their local hospitals. Students have been invited to Auxiliary programs on this subject. State Meetings have been attended by the State Chairman and President when possible.

Mental Health

Our whole State, for the past few years and especially the last two, has been involved in trying to improve mental health conditions and this has given us an op-

portunity to work with them in many ways. Mental health conferences have been attended and information sent to all auxiliaries. Programs have been given to better acquaint all members with this problem. Gifts have been sent to our state institutions. Donations and gifts have been given to retarded children in their schools.

Safety

This has been a priority this year with stress on water safety. Boating safety, swimming lessons, and life saving have been stressed. Bicycle safety contests have been conducted. Safe driving contests have also been conducted in other auxiliaries. These had an award given at the end of the contests. Vacation safety programs, first aid, poison, and fire safety have been stressed. Safety talks on radio and films have been used by many auxiliaries. One auxiliary had a poster placed in the Chamber of Commerce window and all accidents that happened in the community were marked on a map marking the place of the accident. This served to make those in the community more alert and conscious of the need for more safety.

Civil Defense

Programs, films, and lectures have been given in auxiliaries to furnish more information on home preparedness and survival. Work in conducting surveys, cooperating with our Medical Society has been done. Working with local Civil Defense Chairman has been helpful to our members. Our Civil Defense Chairman for our State Auxiliary is also a National Regional Chairman for National Auxiliary. Many home shelters have been equipped by Auxiliary members.

William R. Dancy Student Loan Fund

In the passing of Dr. Dancy this year we have lost a good friend and much regret was caused. Five loans have been made this year and we have four requests pending. It is our hope that sufficient funds will be available to make these loans possible. Our total receipts to this fund will be made at Convention. Many memorial gifts were made in memory of Dr. Dancy.

Today's Health

We no longer maintain Today's Health Committee, as such, but we do give gift subscriptions to libraries, schools, and beauty parlors. Some auxiliaries that have the price of the magazine included in their dues are still having the subscriptions sent to them and this number is well over 400 this year.

Research and the Romance of Medicine

Papers on the lives of doctors in our State have been submitted this year as well as the history of some county medical societies have been written and sent to the State Chairman.

Doctor's Day

As always, this is a day that doctors and wives look forward to each year. Celebrations were observed in most counties. Last November the Doctor's Day award was given to one of our auxiliaries by the Woman's Auxiliary to the Southern Medical Association and it is the hope that it can be returned again this year.

Publications

Our *Auxiliary News* has had a good year and continues to keep each member in our State informed with information that they may not get from any other source. It is published four times a year and is financed by the MAG. We find that our Directory is useful to all members and this is published by MAG, also our compiled reports from Board Meeting of the Chairman of Standing Committee is done by MAG.

Rural Health

This is a new Committee that has been made temporary for this year until it can be voted into our Bylaws. A chairman was appointed by the President and chairmen for many county auxiliaries have been appointed. The State Chairman has started the ground work for what we believe will be one that will function to advantage when well established. The National Rural Health Conference, one of two held in the U.S.A., was held in Atlanta, Georgia, and was attended by the State Chairman and the President of our Auxiliary.

This report represents what all members of auxiliaries, officers, and chairmen and others have done to make for progress in our work this year and only through this cooperation could this report be given. To serve in the capacity of President of such an organization one can really know what good work is being done and feel that all working together is one of the most rewarding experiences that a President can have and grateful gratitude is extended to each member of both the Auxiliary and the Medical Association.

REFERENCE COMMITTEE RECOMMENDATION—This report was approved and commended. The Committee expresses sincere appreciation for their support and tireless work in behalf of the doctors of Georgia.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman's Auxiliary to the Medical Association of Georgia as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Chairman of Reference Committee No. 2, J. Bothwell T aylor, Athens, and duly seconded that the report of Reference Committee No. 2 be approved as a whole and it was so ordered.

Report of Reference Committee No. 3

Leo Smith, M.D., Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendations and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 3 met at 8:00 A.M. on May 8, 1961, in Room 1012, Biltmore Hotel, Atlanta, Georgia. Members present were: Leo Smith, Waycross, Chairman; J. H. Deaton, Columbus, Vice Chairman; Ralph Davis, Rome, Secretary; J. L. Alexander, Savannah, Acting Secretary; Bernard P. Wolff, Atlanta; I. D. Hellenga, Toccoa; William B. Dillard, Jr., Cartersville, and Melvin E. Smith, Milledgeville.

AMA DELEGATES

EUSTACE A. ALLEN, M.D., *Atlanta*;

J. W. CHAMBERS, M.D., *LaGrange*;

HENRY TIFT, M.D., *Macon*

A new decade is in the making. The year 1960 began a new era in American history. It started off with a bang. A new frontier with a go forward movement in keeping with the "do it yourself spirit." It includes a wide socialistic program; it has stirred the people into more active thinking and doing. As to whether we accelerate our socialistic program or retain our freedom depends on our ability to direct the people's thinking. I hope this forward movement has permeated the medical profession.

The 109th annual session of American Medical Association was held in Miami. The House of Delegates took action to prove, once again, that medical practice in a free society is the most effective way. That physicians, free to conduct their practice as in the past will continue to deliver that type of practice which has made America the healthiest nation in the world.

There were 46 resolutions introduced covering many phases of medicine. Among the more outstanding subjects were health care of the aged—a most vital issue, medical education, voluntary health insurance, the related problems of the third-party medicine, occupational health programs, pharmaceutical, and to urge individual members to take a more active part in public affairs on all levels.

The House of Delegates adopted the following statement on "Health Care of the Aged."

"Personal medical care is primarily the responsibility of the individual. If he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state and only when all these fail, the federal government, and then only in conjunction with other levels of government, in above order."

The determination of medical needs should be made by physicians and the determination of eligibility should be made at the local level with local control.

The American Medical Association was asked to offer a group annuity or retirement program to be set up by the American Medical Association. The Association reaffirmed its support of the Blue Shield's concept in voluntary health insurance, sponsored a second National Congress on prepaid health insurance, and established a new achievement award to be given to a non-physician scientist. It recommended a postage stamp commemorating the Mayo Brothers.

Dr. Leonard W. Larson of Bismarck, North Dakota was elected President-Elect. He will speak before the Medical Association of Georgia at the 1961 Atlanta meeting. Dr. William F. Costello of Dover, New Jersey was selected as Vice President; Dr. Gerald Dorman of New York City to the Board of Trustees, and Dr. Julian Price of Florence, South Carolina, became the new Chairman of the Board of Trustees.

The American Medical Association Distinguished Service Award was given to Dr. Charles A. Doan, Dean of Ohio State Medical College. Dr. John S. Mills, President of Western Reserve University, Cleveland, Ohio was our guest speaker at the inaugural ceremonies. At

the Miami meeting seven Southeastern states held open house daily. It was well attended and was considered a success. This was a way that the smaller states could repay the larger ones for their continuous hospitality. All three of your Delegates attended all meetings of the House of Delegates.

The 14th clinical session was held in our National Capital the last week of November. About 30 resolutions were considered by the House of Delegates. Among these were: an initial scholarship and loan program for medical students, the status of foreign medical graduates, American Medical Association membership dues be increased, the expansion of voluntary health insurance, and health care of the aged. Dr. James T. Cook of Marianna, Florida was named General Practitioner of the year.

Dr. Askey said we must meet the challenges of society. He stated the principle of the freedom of the individual, both patient and physician, and better medical care are far more important than political expediency. The Mills Kerr Bill was strongly backed by the House of Delegates. It represents the first piece of legislation which permits the development of a sound system of medical care for the aged.

The American Medical Association meets in New York City the last week in June, 1961. Your Delegates would like for you to visit us at Convention Headquarters at the Statler-Hilton Hotel.

REFERENCE COMMITTEE RECOMMENDATION—The report of the Delegates to the American Medical Association was approved and commended. Dr. Henry Tift, Delegate to the AMA, reported to the committee that Dr. Eustace A. Allen is to be nominated as Vice President of the AMA at the next meeting. Reference Committee No. 3 recommends that the Georgia delegation to the AMA do so.

HOUSE OF DELEGATES ACTION—Speaker Walker recognized President Hatcher who discussed the MAG Council endorsement of Eustace A. Allen for the office of Vice President of the American Medical Association. On motion (Scoggins-McDaniel) it was voted that the MAG House of Delegates does hereby endorse the candidacy of Eustace A. Allen, M.D., Atlanta, for the office of Vice President of the American Medical Association.

The House then adopted the report of the AMA Delegates as recommended by the Reference Committee on motion duly made and seconded.

COUNCIL OF MAG

J. G. MCDANIEL, M.D., *Chairman*

Gentlemen of the House of Delegates:

The Medical Association of Georgia has had the busiest single year in its long history. Councilors and vice councilors have worked with zeal and enthusiasm as evidenced by their almost 100 per cent attendance at Council and Executive Committee of Council meetings. Let me express my appreciation to the members of Council for their prompt attendance which allowed our meetings to be convened on time with a quorum present.

At the May 4, 1960 Council organization meeting, J. G. McDaniel, Atlanta, was reelected Chairman. Virgil Williams, Griffin, was elected Vice-Chairman. Edgar Woody, Jr., Atlanta, was reappointed Editor of the *JMAG*. Virgil Williams was reappointed Chairman

of the Finance Committee and Raymond C. Arp, Atlanta, was reappointed Treasurer of the Association. Mr. M. D. Krueger was reappointed Executive Secretary for the year 1960-61.

During the year 1960-61, in addition to the efforts of the officers, councilors, and vice-councilors, I wish to particularly note the cooperation Council has received from the Council Committees, the Association Standing Committees, and the Special Committees. Their activity has been outstanding and their contribution to the profession self-evident. Our Association President Dr. Milford B. Hatcher, Macon, has been an inspiring leader during his term of office as President. The Association President-Elect, Fred Simonton, Chickamauga, has shown keen interest in all Association activities and has given great indication of his potential as a leader of the profession for next year. Our Immediate Past President, Luther Wolff, Columbus, has maintained the same high degree of interest in the Association affairs that he did during his term of office as President last year. The Association's Secretary, John T. Mauldin, Atlanta, has given time daily in the fulfillment of the duties of his office. He has augmented the "team" spirit of MAG leadership and deserves our wholehearted support and thanks. Raymond C. Arp, Atlanta, the Association Treasurer, has continued with his duties of this responsible office in a most efficient manner, giving a monthly report on income and expenditures to Council and its Executive Committee. Edgar Woody, Jr., Editor of the *Journal of the Medical Association of Georgia*, continues his fine work on our journal and the excellence of this publication certainly reflects credit on the entire MAG membership. Chairman of Finance, Virgil Williams, Griffin, prepared and presented the annual budget of the Association which was approved by Council. He and his fine committee are certainly to be commended for their activity. Dr. Williams is Vice-Chairman of Council and has served extremely well in this capacity.

The Executive Secretary, Mr. Milton D. Krueger, has functioned most efficiently in behalf of the Association. He has worked many long hours and weekends, far beyond the call of duty. Mr. James M. Moffett, Assistant Executive Secretary, though he has been employed only a short time, has ably demonstrated his abilities. He is a fine addition to the Headquarter's Staff. I believe I speak for the Association Council when I say that we all wish Mr. John F. Kiser "the best of it" in his new position with the American Medical Association—after his resignation from our Association on February 1, 1961. A special word of thanks is due Mrs. Catherine Wooten, Administrative Assistant on the Headquarter's Office Staff. Miss Thelma Franklin and the other members of the MAG Staff have contributed immeasurably to the success of the Headquarters Office. I would also like to commend Mr. Frantz Lipsey, new MAG Medicare Administrator, for his performance in the administration of the Medicare program.

Below is a resume of the highlights of the Council and the Executive Committee of Council activities during the year 1960-61:

- (1) Fifty-year pin changed to single serpent caduceus representing medicine.

- (2) Stimulation of Student American Medical Association activities.
- (3) Stipulated that a chairman of AMA delegation be appointed annually by Council.
- (4) Implemented House of Delegates action to enlarge Council from 17 voting members to 22.
- (5) Strong support of Kerr-Mills Bill endorsed by Council.
- (6) Authorized "brief case" notebook for county medical society secretaries to aid them in conduct of their official business.
- (7) Encouraged physicians' participation in observance of civic vote campaign for election day.
- (8) Supported MAG Athletic Injury Conference at Columbus.
- (9) Adopted MAG policy in regard to practice of osteopathy.
- (10) Authorized participation in Governor's Commission on Aging.
- (11) Appointed a Relative Value Study Committee.
- (12) Authorized participation on Governor's Study Committee on Health Care of Aging to draft implementing legislation for Kerr-Mills Law.
- (13) Published and distributed Physician-Lawyer Code of Cooperation.
- (14) Retired an additional \$5,000 on Headquarters Office Building mortgage above and beyond annual payment.
- (15) Called "Special" meeting of entire membership for Legislative Conference, Macon.

Below are listed the reports as submitted by the various Council Committees:

Finance

VIRGIL WILLIAMS, M.D., *Chairman*

The following budget was approved by Council for 1961:

	1961 Budget
INCOME	
I. (a) MAG Dues	\$100,680.00
(b) Int. & AMA	800.00
(c) GP Service	2,820.00
(d) Funds Carried 1960	9,720.24
II. Annual Session	9,625.00
III. Journal	50,000.00
TOTAL INCOME	\$173,645.24

EXPENSES SUMMARY

I. (a) Fixed Allotments	\$ 14,300.00
(b) Assoc. Office	68,073.00
(c) MAG Committees	15,050.00
(d) Contingent Fund	14,123.99
II. Annual Session	9,965.00
III. Journal	52,133.25
TOTAL EXPENSES	\$173,645.24

LIQUID FUNDS AVAILABLE

Securities (Gov. Bonds)	\$12,840.00
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Detailed Itemization of Budget Expenses

I. (a) *FIXED ALLOTMENTS*

	1961 Budget
Payment on Mort.	\$ 4,000.00
Interest on Mort.	2,000.00
MAG Atty. Expenses:	
Retainer	2,400.00
Expenses	500.00
Woman's Aux.	1,500.00
Pension Payments	2,400.00
President's Honorarium	1,000.00
Annual Audit	500.00
(A) Sub-Total	\$14,300.00

(b) *ASSOCIATION OFFICE*

Salaries	\$37,675.00
Bonus	1,787.50
Ins. and Bond	1,100.00
Payroll Taxes	2,260.50
Travel:	
Office	4,000.00
Del. Sec. to AMA	—
Annual & Clinic	2,000.00
Maint. & Repair:	
Building	2,500.00
Equipment	750.00
Tel. & Tel.	4,200.00
Depreciation:	
Building	2,400.00
Equipment	1,200.00
Postage	3,000.00
Office Supplies	2,500.00
Jan. Serv. & Grat.	1,300.00
Meetings	750.00
Dues & Sub.	200.00
Heat, Light & Water	2,100.00
Sundry	350.00
	\$70,073.00
Less Charge to A.S.	2,000.00
(B) Sub-Total	\$68,073.00

(c) *MAG COMMITTEES*

1. AMA Del. Meet.	\$ 500.00
2. Awards	200.00
3. Crawford W. Long	500.00
4. Health Care Aging	1,400.00
5. Health Column	1,900.00
6. Hosp. Relations	600.00
7. Industrial Health	300.00
8. Ins. & Econ.	500.00
9. Inter. Council	200.00
10. Legislation	2,000.00
11. Mat. & Inf. Wel.	200.00
12. Med. Civil Prep.	150.00
13. Medical Defense	1,000.00
14. Medical Education	100.00
15. Med. School Course	100.00
16. Mental Health	250.00
17. Phy.-Law. Liaison	300.00
18. Prof. Conduct	50.00
19. Public Service	2,000.00
20. Rural Health	200.00
21. SAMA	500.00

22. Sch. Child Health	1,900.00
23. Scientific Awards	50.00
24. SMEB	100.00
25. VFW Liaison	50.00
(C) Sub-Total	\$15,050.00

(d) *CONTINGENT FUND*

1961 Contingent	\$ 4,403.75
1960 Unappropriated	4,720.24
1960 Additional Payment on Mort.	5,000.00
(D) Sub-Total	\$14,123.99

II. *ANNUAL SESSION*

Expenses	\$ 7,965.00
Sec. & Ofc. Exp.	2,000.00
TOTAL	\$ 9,965.00

III. *JOURNAL*

Expenses:	1961 Budget
Printing	\$40,000.00
Salaries	5,700.00
Bonus	662.00
Ins. & Bond	189.00
Payroll Taxes	381.75
Engraving & Cuts	1,800.00
Sales Tax	1,200.00
Postage	500.00
Stationery	500.00
Clipping Service	350.00
Addressograph & Sup.	250.00
Editorial Asst.	250.00
Meetings	300.00
Sundry	50.00
TOTAL	\$52,133.25

Committee Reorganization

GEORGE R. DILLINGER, M.D., *Chairman*

Your committee on Committee Reorganization worked out a system whereby there would be four MAG Committees and 12 Boards which would carry on the activities of the Association. This was approved in principle by the Council and referred to the Committee on Constitution and Bylaws for action.

At the present time the Medical Association of Georgia is functioning with a hodge podge of 20 Standing Committees and some 30 Special and Council Committees.

The House of Delegates at the Annual Session instructed Council to recommend consolidation or reorganization of the Committee setup.

Your committee believes that by changing to a Board or Commission form of organization, the interests and activities of the Medical Association of Georgia may best be served.

The committees hereinafter mentioned would continue to function as at present.

Each Board should consist of 15 members, five to be appointed each year. The Board would be organized with a chairman, vice chairman, and a secretary; these three, together with two other members, would constitute an Executive Committee for the transaction

of business. Subcommittees would deal with special problems, then report to the Board!

At the present time some committees report directly to the House of Delegates, some report to Council, some to the President of the Association, and many make no reports at all. It is recommended that all boards and committees report directly to Council, except in case of emergency, when a report may be made to the Executive Committee.

Your Committee recommends that the following suggested organization be approved and referred to the Committee on Constitution and Bylaws, for the changes that must be recommended to the House of Delegates.

COMMITTEES — MEDICAL ASSOCIATION OF GEORGIA

1. Executive Committee
2. Finance Committee
3. Committee on Woman's Auxiliary
4. Committee on Professional Conduct

BOARDS — MEDICAL ASSOCIATION OF GEORGIA

PROFESSIONAL ACTIVITIES

1. Medical Education
2. Hospital Activities
3. Governmental Medical Services
4. Volunteer Health Agencies
5. Occupational Health
6. Interprofessional Relations

ADMINISTRATIVE ACTIVITIES

7. Public Service
8. Legislation
9. Insurance and Economics
10. Constitution and Bylaws
11. Annual Session
12. Special Activities

Medical Courses Committee

CHRISTOPHER J. McLoughlin, M.D., *Chairman*

Five years ago at the request of some recent medical school graduates, a series of lectures was instituted on "The Art of The Practice of Medicine." These lectures were designed for senior medical students to inform them of some of the problems they would meet in the practice of medicine which were not covered in the scientific courses in medical school.

Students who have attended these lectures have profited greatly by them, and a copy of the lecture material has been presented to each student in order that it may be used as reference in later years. So important are these lectures, that a pharmaceutical house has completed a series of audio-visual lectures with beautifully illustrated booklets accompanying each lecture.

These lectures have been well received at the Medical College of Georgia and are delivered on alternate Saturdays in the spring of each senior year. The final lecture is accompanied by a luncheon to which the students are invited to bring their wives or sweethearts. Unfortunately, Emory University has been reluctant to fit this program into its schedule.

Judging from some of the favorable comments we have received, it is felt that these lectures are of considerable value to the soon-to-be-physicians, and it is

urged that they be continued and, if possible, made available to the students of Emory.

Clarksville Laboratory School

CHARLES R. ANDREWS, JR., M.D., *Chairman*

In November, the Advisory Committee to the School for Medical Laboratory Assistants met for overall discussion concerning the laboratory school. Of the five students entering the course of training in the first class, four remain and they are in the second phase of their course which involves practical training in selected hospitals. Twenty students entered the course September 1960. New facilities for the course were made available.

It is not felt necessary to go into details of overall discussion of the committee except to point out that pertinent phases which would be of interest to the Medical Association of Georgia were brought into the open such as proper selection of equipment, proper interview of students by pathologist and medical technologists, dissemination of information concerning the program, curriculum, and student performance. Certain reservations concerning the program in general pointed out and suggestions made and discussed. Graduates of the school are continued to be given a diploma with a designated "Medical Laboratory Assistant."

A sub-committee was appointed to discuss a possibility of graduates of this school in the framework of organized medicine. This later action is specifically the reason for this committee. It is recommended that the committee be continued for direct information to the Medical Association of Georgia concerning the laboratory school.

Annual Session

HENRY H. TIFT, M.D., *Chairman*

It is the duty of the Annual Session Committee to plan and carry out the program for the Annual Session of the Medical Association of Georgia. This meeting will be held May 7-10, 1961, at the Biltmore Hotel in Atlanta, Georgia. The Official Program for this meeting is, in fact, the report of this Committee, and it will be placed in the hands of all members of the Medical Association of Georgia. I wish to thank the other members of my Committee for their splendid cooperation during the year. I also wish to thank Dr. Mark S. Dougherty and Dr. Linton H. Bishop, Co-Chairmen of the Local Arrangements Committee of the Fulton County Medical Society on whose shoulders falls the major burden of presenting a successful Annual Session.

The criticism which I have heard most frequently in reference to recent Annual Sessions is that they have become too specialized. Many of our members feel that our meetings were better during the years when there were no section meetings for the various specialties, but rather one general session daily for everyone to attend.

I respectfully request that the Chairman of Council appoint a new Annual Session Committee Chairman for 1962 in order to inject new ideas for future programs.

Health Care of Aging

JOHN S. ATWATER, M.D., *Chairman*

In the 1960 report of this Committee, there were three phases stressed; namely, orientation, organization, and education. The 1961 Committee report lays emphasis upon the last of these, education. During the past year multiple avenues of approach were used.

To the medical profession itself, the committee spoke through editorials, through visits to county and district medical societies, and as the host to the Southeastern Regional Conference on Aging. To the paramedical and closely interrelated groups, the committee members joined forces to disseminate information on the basic medical concepts and to discuss related aging problems. For the second year the Georgia Joint Council to Improve the Health Care of the Aging made possible the unity of purpose between the Medical Association of Georgia and three other groups, specifically, the Georgia Hospital Association, the Georgia Dental Association, and the Georgia Association of Nursing Homes and Homes for the Aged. We participated in a teaching course for nursing home administrators and spoke to the Georgia Nutrition Council and the Georgia Nursing Association. Problems of aging were discussed with the Veterans Administration, both locally and in other Southeastern facilities.

At a national medical level, one member served on the National Speaker's Bureau and as a consultant to the Council on Medical Services (Committee on Aging) of the American Medical Association. Vigorous participation in the White House Conference on Aging was performed by several committee members as well as several officers of the Medical Association of Georgia. In the Committee on Financing Health Care at the White House Conference on Aging, the Georgia representation had the distinction of being the only group to win the opposition to the compulsory health care plan forcing the vote in favor of the voluntary local level approaches. This was, in essence, the carrying out successfully of the charge given to it by this Association. In addition, one member served as the liaison man between the White House Conference on Aging and the American Medical Association. Both social and informal talks with our national and State senators and legislators were undertaken.

Working through the Governor's Commission on Aging, one member acted as Chairman of the Governor's Conference on Aging, held in Athens, Georgia. A motion picture film on the aging problem in Georgia was developed. As Chairman of the Health Committee of the Governor's Commission on Aging, one member guided a survey of the health needs and resources of the aging in Georgia. This is now published in the papers of the Commission.

Education of the people of Georgia and of the South came through many appearances before civic and social groups, as well as a number of radio and television appearances. The volume of mail and telephone calls following each program indicated the deep interest and concern our people have toward aging, and especially toward Federal intervention in the financing aspects.

The members of the Committee would like to thank the members of the Council, the officers, and other members of the Medical Association of Georgia, who

have supported so effectively the suggestions and work of this committee.

Recommendations

The recommendations of this committee are basically similar to those of the 1960 report. It is recommended that:

- 1. The special committee on the Health Care of the Aging be continued.
- 2. That continued support be reaffirmed to the Georgia Joint Council to Improve the Health Care of the Aging.
- 3. That continued support be reaffirmed to the Governor's Commission on Aging.
- 4. That the Medical Association of Georgia reaffirm its position as being opposed to compulsory health insurance programs.
- 5. That the Medical Association of Georgia urge its members to actively participate in and work with other members of their local county committees on aging.

REFERENCE COMMITTEE RECOMMENDATION — The report of the Council of the MAG was approved and commended. This Committee wishes to especially commend Dr. McDaniel for his untiring efforts in behalf of Council and the MAG.

HOUSE OF DELEGATES ACTION — Adopted the report of the Council of the Medical Association of Georgia as recommended by the Reference Committee on motion duly made and seconded.

FIRST DISTRICT COUNCILOR

CHARLES T. BROWN, M.D., *Guyton*

Due to the fact that I have been away on educational leave at the University of North Carolina since September, 1960, it has been impossible for me to be active in the capacity of Councilor. The last meeting that I attended was just prior to our Annual meeting in May, 1960, and since that time, Vice-Councilor, Dr. T. A. Peterson, of Savannah, Georgia, has ably represented the First District during my absence. I am not aware of any problems in the First District at this time.

I wish to express my deep appreciation to Dr. Peterson, who has so faithfully represented the First District during my absence, and it is my sincere wish that the association enjoy a most successful Annual Meeting in May.

REFERENCE COMMITTEE RECOMMENDATION — This Committee approved and commended the report of the First District Councilor.

HOUSE OF DELEGATES ACTION — Adopted the report of the First District Councilor as recommended by the Reference Committee on motion duly made and seconded.

FIRST DISTRICT VICE-COUNCILOR

T. A. PETERSON, M.D., *Savannah*

As Vice-Counselor for the First District Medical Society, it has been my pleasure and privilege to attend all the meetings of Council and to participate in returning the necessary information that was pertinent to the First District to the interested societies of our district.

This will be the conclusion of my services as Vice-Councilor from the First District because of the change in Councilor distribution. Henceforth, there will be a

Councilor elected from the Georgia Medical Society for that area alone; in addition to a Councilor representing the balance of the First District.

It has been indeed a pleasure to serve in this capacity throughout the past year and prior to that to serve as Vice-Councilor, under the very able directorship of Dr. Charlie Brown.

Counties and Secretaries	Members December 31, 1960		Members December 31, 1959	
	MAG	AMA	MAG	AMA
Bulloch-Candler-Evans				
Robert Pence				
Metter	19	17	18	16
Burke				
C. G. Green				
Waynesboro	8	5	8	6
Emanuel				
R. G. Brown				
Swainsboro	7	7	8	7
Georgia Medical Society				
Jeff Holloman				
Savannah	155	137	149	134
Jenkins				
A. P. Mulkey,				
Millen	2	2	3	3
Screven				
J. C. Paul, Sylvania	5	5	5	5
Southeast Georgia				
John McArthur				
Lyons	21	15	22	18
Tri-Liberty-Long				
McIntosh	2	2	2	1
	219	190	215	190

REFERENCE COMMITTEE RECOMMENDATION — This Committee approved and commended the report of the First District Vice Councilor. (The First District Vice Councilor acted as Councilor in the absence of the First District Councilor.)

HOUSE OF DELEGATES ACTION — Adopted the report of the First District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

SECOND DISTRICT COUNCILOR

GEORGE R. DILLINGER, M.D., Thomasville

There has been little change in the membership of the Second District during the past year, however, I feel that the medical societies are more active. The Dougherty County Medical Society is to be commended for their southwest Georgia Medical Seminar, beginning graduate medical education to southwest Georgia. On February 23rd this year a session was held and the faculty participating was from the Medical College of Georgia.

Thomas-Brooks Medical Society put on a seminar in the month of December on Heart and Circulatory Diseases. This was a joint effort sponsored by the Thomas-Brooks Medical Society and Medical Section of the Veterans' Administration Facility located in Thomasville.

Bringing meetings of this type to the local areas is

one of the best methods of presenting graduate education.

Other medical societies in the district have been active but the Councilor has had no reports of their activity.

Counties and Secretaries	Members December 31, 1960		Members December 31, 1959	
	MAG	AMA	MAG	AMA
Colquitt				
James Flynn				
Moultrie	18	15	18	14
Decatur-Seminole				
M. A. Ehrlich				
Bainbridge	17	16	17	15
Dougherty				
Ben J. Giles				
Albany	50	37	46	30
Grady				
William Morton				
Cairo	6	6	4	4
Mitchell				
A. A. McNeill, Jr.				
Camilla	11	9	10	9
Southwest Georgia				
Robert Jennings				
Arlington	13	11	15	10
Thomas-Brooks				
Julian B. Neel				
Thomasville	40	32	37	31
Tift				
P. W. Lucas				
Tifton	14	11	15	14
Worth				
H. G. Davis, Jr.				
Sylvester	4	4	6	4
	173	141	168	131

REFERENCE COMMITTEE RECOMMENDATION — This Committee approved and commended the report of the Second District Councilor.

HOUSE OF DELEGATES ACTION — Adopted the report of the Second District Councilor as recommended by the Reference Committee on motion duly made and seconded.

CANCER

HOKE WAMMOCK, M.D., Chairman

During the past year there have been no changes in the function of the standing Committee on Cancer. It continues to serve in an advisory capacity with the Division of Cancer Control, Department of Public Health, Dr. W. J. Murphy, Director of the Cancer Control Service. The activities during the past year have operated in a very smooth manner.

Perhaps the most significant change has been a five per cent reduction in the case load of cancer State aid patients during the past year. Contrariwise, hospitalization costs have shown a slight increase, and because of this the cost of operation of the Cancer Control Program continues about the same.

The Committee has approved the continuation of the Cancer Bulletin to the physicians in the State. By the

continuation of this bulletin, it is hoped that the physicians will take advantage of the opportunity of reviewing this bulletin to gain current knowledge on the subject of cancer.

Senate Bill 32 was recently passed by the 1961 Georgia General Assembly. As for implementation of this measure, it is too early to predict. MAG has members on the Advisory Council to assist in the implementation of this program of Medical Assistance to the Aged and Old Age Assistance. The manner of implementation of these medical care bills to the aged has not been determined at this writing, and thereby it is not possible to predict or state how the Cancer State Aid Program will be affected. It is hoped that there will be liaison established by the MAG Advisory Council with the Cancer Committee.

The indigent cancer patient in the State of Georgia continues to receive excellent care by virtue of the availability of Cancer State Aid Clinics within a short distance of every patient. Despite this care, it is incumbent upon us to work even harder with our Cancer Control Program of education of the laity and the physician in order that the patient will receive the latest in diagnostic and therapeutic procedures.

REFERENCE COMMITTEE RECOMMENDATION — This Committee approved and commended the report of the Cancer Committee.

HOUSE OF DELEGATES ACTION — Adopted the report of the Cancer Committee as recommended by the Reference Committee on motion duly made and seconded.

CONSTITUTION AND BYLAWS

THOMAS GOODWIN, M.D., *Chairman*

The Council of the Medical Association of Georgia referred to the Constitution and Bylaws Committee a suggested plan for revising Service Membership in the Medical Association of Georgia. As this plan would require an amendment to the Bylaws of the Association's Constitution and Bylaws the following report is presented for your consideration:

NOW READS:

Entitled: Chapter I—MEMBERSHIP, Section V—SERVICE MEMBERS. Physicians eligible for Service Membership are all full-time commissioned Medical Officers of the Government, in the U.S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration, and Indian Service, and those physicians who have retired from the Services by federal law. Such members shall not be required to pay the annual dues and shall not be entitled to vote and hold office and shall not have the privilege of Medical Defense, nor shall they receive any publication of the Association except by personal subscription.

WILL READ:

Chapter I—MEMBERSHIP, Section V—SERVICE MEMBERS. Physicians eligible for Service Membership are all full-time commissioned Medical Officers of the Government, in the U.S. Army, Navy, Air Force, United States Public Health Service, Veterans Administration, and Indian Service, and those physicians who have retired from the Services by federal law. *Service members need not be licensed to practice medicine in the State of*

Georgia provided they are physicians holding the degree of Doctor of Medicine or Bachelor of Medicine from a medical college acceptable to the Council of the Association. Such members shall not be required to pay the annual dues and shall not be entitled to vote and hold office and shall not have the privilege of Medical Defense nor shall they receive any publication of the Association except by personal subscription.

This matter was discussed at the Council meeting concerning the problem of physicians employed by federal agencies who are not licensed to practice medicine in the State of Georgia. Section V, Chapter I of the present Bylaws of the Medical Association of Georgia provides the category of Service Membership for these Medical Officers. An ambiguity arises as to whether the provisions of Section I of Chapter I of the Bylaws apply also to those who wish to become members of the component and State medical societies in the category of service members in regard to licensure in the State of Georgia. To make this point clear the proposed amendment would provide that Georgia licensure in the State of Georgia *not* be a qualification for Service Membership.

REFERENCE COMMITTEE RECOMMENDATION — This Committee approved the regular report of the Constitution and Bylaws Committee.

HOUSE OF DELEGATES ACTION — Adopted the report of the Constitution and Bylaws Committee as recommended by the Reference Committee on motion duly made and seconded.

MATERNAL AND INFANT WELFARE

EUGENE L. GRIFFIN, M.D., *Chairman*

During this last year the Maternal Section of the Committee met three times, the Perinatal Section met formally once, and there have been several informal conferences with individuals. Both the Maternal and Perinatal Sections were well represented at the American Medical Association Regional Meeting on Perinatal Mortality.

For the purposes of clarity, each section report is presented separately.

Maternal Section

The Maternal Section has reviewed and classified approximately 150 case reports of maternal deaths and made suitable recommendations or other suitable disposition for each. While many of the cases are beautifully worked up, complete with necropsy reports in many cases, the Committee had to function on a minimum of information.

The Committee is deeply concerned that an increasing number of deaths are directly related to either failure to seek prenatal care or inadequate and delayed prenatal care, and delayed hospitalization for management of abnormalities. The Committee recommends that every effort be made on the part of local medical groups to sponsor early and good prenatal care and some kind of minimum cost plans for hospitalization for delivery of all patients, and recognizes that the greatest problem lies outside the five or six highly organized areas of the State. It is chiefly a rural and semi-rural problem, where

non-medical attendants and home deliveries still play a big role. Some of the larger population counties with sizable hospitals still have large case loads of midwife deliveries. They should be in position to make some changes in this.

As far as professional management is concerned, the Committee feels that it should be the concern of each physician responsible for management of toxemia, pre-eclamptic or eclamptic to use the most modern and acceptable methods, including hospitalization as early as possible. An educational program is planned on an individual basis, using the Emory and Medical College suggestions for management.

As far as the Committee is concerned, and on the basis of case review, the practice of internal version and extraction is still far too frequently used and directly responsible for fatal terminations.

Criminal abortions with infections contributed all too significantly to the still high maternal death rate. Apparently this problem is increasing and may need special study.

Hemorrhage, long a leading cause, seems to have been less frequent. Apparently, one factor is improved blood bank facilities.

Attention is again called to our responsibility in determining that a patient is really safe for delivery by a non-medical attendant—lay midwife—where this is still necessary. If the patient is not considered safe, such permit should be refused, and every attempt made to get hospitalization for management and/or delivery. The Talmadge Memorial Program should do much to implement this.

Perinatal Section

This section commends the fact that one of the large hospitals in the State is to be included in the American Medical Association Perinatal Study. It is regretful that the AMA records for hospitals provides that only one of the newborn record sheets can be retained by the hospital. This gives no record sheet for the infant chart, just for the mother's chart. But it feels that on the whole, the AMA committee has helped make great progress possible.

At the State level, Committee efforts have been directed toward correlating maternal and infant factors related to perinatal loss. It is felt that progress has been made. An exhibit will be on display at the annual meeting, 1961.

In view of the future studies and work indicated, the chairman of the overall Committee and active Committee members recommend that:

(1) A perinatal mortality committee, separate from the Maternal and Infant Welfare Committee, be set up. This action would seem logical in view of the American Medical Association Perinatal Program.

(2) Representation of obstetric and general practice be increased, regardless of whether or not a separate committee be set up.

Budget

The Maternal and Infant Welfare Committee respectfully requests that their budget be doubled in order to continue the registered letter program so successful in the past year, and to permit official representation at the annual Four-State Obstetric-Pediatric Seminar, to be

held this year in St. Petersburg, Florida. It is desirable that every sponsoring State Committee is officially represented. In the past, the Georgia Committee has not been.

It is anticipated that other activities may increase.

REFERENCE COMMITTEE RECOMMENDATION—The report of the Maternal and Infant Welfare Committee is approved and commended. It is the recommendation of this Committee that the MAG Council strongly consider the recommendation for budgetary increase and for appointment of a Perinatal Mortality Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Maternal and Infant Welfare Committee as recommended by the Reference Committee on motion duly made and seconded.

MEDICAL DEFENSE

CHARLES S. JONES, M.D., *Chairman*

It is with satisfaction that your Professional Liability Committee can report that there are nearly 2,200 of the 2,500 actively practicing doctors in the State of Georgia who are participating in the cooperative program which protects the medical profession in the event of professional liability. Each year the joint administration of this program works more smoothly and the results have been satisfactory both to the doctors of Georgia and to the insurance carrier.

At a time when professional liability claims are increasing in number, and in amount, it is gratifying to know that the various committees over the State have been able to work closely in a program which has been of genuine benefit to all concerned. There are no plans at present to change any of the major features of our Professional Liability Insurance Program.

REFERENCE COMMITTEE RECOMMENDATION—This Committee approved and commended the report of the Medical Defense Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Medical Defense Committee as recommended by the Reference Committee on motion duly made and seconded.

CRIPPLED CHILDREN

JACK C. HUGHSTON, M.D., *Chairman*

The Crippled Children's Committee is glad to report that in April 1961, the duPont de Nemours Foundation of Wilmington, Delaware, is once again sponsoring a conference in Georgia relative to the handicapped child and the facilities available for the handicapped in the State of Georgia. This conference has stimulated much interest. The last such conference was in 1955. We are anticipating that this conference with the duPont de Nemours Foundation can be conducted in such manner that the conferences can be held with some regularity each year or once every two years. These conferences will be held at various larger towns within the State of Georgia.

Miss Mary Webb, of the Association of Crippled Children and Adults, is helping greatly in the development of this conference and this organization is one of the co-sponsors. Aside from this conference, this organi-

zation is continuing to do a progressive job in the State of Georgia in bringing rehabilitation to the local level.

The quality of coverage for the handicapped children under the auspices of the Crippled Children's Division of the Public Health Department has constantly improved to an excellent level under the fine guidance of Doctor James E. Yarbrough.

The numerous specialty groups, that is, those groups interested in the specific care of one particular disorder, have generally made excellent progress.

We feel that the handicapped child in the State of Georgia would have considerable difficulty in avoiding proper medical care, as it is so well coordinated through the inner working of all these agencies mentioned.

REFERENCE COMMITTEE RECOMMENDATION — The Committee approved and commended the report of the Crippled Children Committee.

HOUSE OF DELEGATES ACTION — Adopted the report of the Crippled Children Committee as recommended by the Reference Committee on motion duly made and seconded.

**Supplementary Report of Constitution
and Bylaws No. B**

COMMITTEE REORGANIZATION

THOMAS W. GOODWIN, M.D., Chairman

Revision of the Bylaws as recommended by the Committee on Committee Reorganization and approved in principle by Council at the December, 1960, and the March, 1961, session and corrected by the Executive Committee at the April, 1961, meeting.

**CHAPTER IV. COUNCIL. SECTION 3
EXECUTIVE COMMITTEE** at present reads:

The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, who shall serve as Chairman of the Executive Committee, the President-Elect, the Immediate Past President, the Secretary, the Chairman of the Executive Committee, who shall serve as Vice-Chairman of the Committee, and the Chairman of the Council Committee on Finance. It shall meet monthly between the meetings of Council. At any duly called meeting of this Committee for which proper notice has been given, any three (3) members of the Committee shall constitute a quorum. The Committee shall make such recommendations to the Council and shall carry out such items of business as are referred to it by Council. The Executive Committee shall appoint all Committee Chairmen and committees of the Association and nominate members of all Boards required by the laws of the State of Georgia on recommendation of the district societies where applicable; not otherwise provided for, subject to confirmation by Council, and shall serve as Publications Committee of the Journal. The Executive Committee shall recommend to Council the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association. The Executive Commit-

tee shall be empowered to select an Executive Secretary who shall be responsible to the Executive Committee for his action and for the operation of the Headquarters office, subject to the approval of Council. The Executive Committee shall act as a Board of Trustees directing the Executive Secretary in carrying out the mandates and policies of the Council and the House of Delegates. Between meetings of the Executive Committee, the Chairman of the Executive Committee of Council or his duly appointed representative shall direct the Executive Secretary as to undetermined matters of policy.

**CHAPTER IV. COUNCIL. SECTION 3.
EXECUTIVE COMMITTEE**, as amended shall read:

The Council shall organize an Executive Committee at the organizational meeting. The Executive Committee shall be composed of the President, who shall serve as Chairman of the Executive Committee, the President-Elect, the Immediate Past President, the Secretary, the Chairman of Council, who shall serve as Vice-Chairman of the Committee, and the Chairman of the Council Committee on Finance. The First Vice President shall serve as an ex-officio member of the Executive Committee, or in his absence the Second Vice-President. It shall meet monthly between the meetings of Council. At any duly called meeting of this Committee for which proper notice has been given, any three (3) members of the Committee shall constitute a quorum. The Committee shall make recommendations to the Council and shall carry out such items of business as are referred to it. The Executive Committee shall appoint all Association Boards and Committees, including Chairmen, and shall nominate members for all Boards required by the laws of the State of Georgia on recommendation of the district societies where applicable; not otherwise provided for, subject to confirmation by Council, and shall serve as Publications Committee of the Journal. The Executive Committee shall recommend to Council the terms of employment and salaries of all personnel necessary to conduct the affairs of the Association. The Executive Committee shall be empowered to select an Executive Secretary who shall be responsible to the Executive Committee for his action and for the operation of the Headquarters Office, subject to the approval of Council. The Executive Committee shall act as a Board of Trustees directing the Executive Secretary in carrying out the mandates and policies of the Council and the House of Delegates. Between meetings of the Executive Committee, the Chairman of the Executive Committee of Council or his duly appointed representative shall direct the Executive Secretary as to undetermined matters of policy.

CHAPTER IV. COUNCIL. SECTION 9. COMMITTEE ON FINANCE, at present reads:

The Chairman of the Council shall appoint from its members a committee of three members to be known as the Committee on Finance, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for

the fiscal year beginning January 1st after each Annual Session. This proposed budget shall be prepared by the Committee on Finance for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

All expenditures made by the Local Arrangements Committee in connection with the Annual Session must be authorized in advance by the Committee on Finance. Council shall have control of all commercial exhibits at the Annual Sessions and any deficit created on account of the Annual Session shall be met by Council on recommendation of the Committee on Finance.

CHAPTER IV. COUNCIL. SECTION 9. COMMITTEE ON FINANCE, as amended shall read:

The Chairman of the Council shall appoint from its members a committee of three members to be known as the Committee on Finance, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each Annual Session. Each Board and Committee shall submit to the Committee on Finance its budget for the following year at such time as the Committee on Finance may designate. This proposed budget shall be prepared by the Committee on Finance for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for approval. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

All expenditures made by the Local Arrangements Committee in connection with the Annual Session must be authorized in advance by the Committee on Finance. Council shall have control of all commercial exhibits at the Annual Sessions and any deficit created on account of the Annual Session shall be met by Council on recommendation of the Committee on Finance.

CHAPTER VI. RIGHTS AND DUTIES OF OFFICERS. SECTION 1. PRESIDENT, at present reads:

The President shall (A) preside at all general meetings of the Association; (B) address the opening general session of the Annual Session; (C) assist the Councilors in improving the county and district societies as far as practicable; (D) serve as a member of Council and as a member of the Executive Committee; (E) serve as a member of all committees of the Association with the authority of all committees of the Association with the authority to call a meeting of any committee when necessity demands it or after failure of the chairman to do so. With the approval of Council, he

may terminate any committee whose function has been fulfilled or replace any member of any committee who fails to show interest in performing the duties assigned to him; and (F) he shall be an ex-officio member of the House of Delegates without the right to vote.

CHAPTER VI. RIGHTS AND DUTIES OF OFFICERS. SECTION 1. PRESIDENT, as amended shall read:

The President shall (A) preside at all general meetings of the Association; (B) report to a general session of the Annual Session; (C) assist the Councilors in improving the county and district societies as far as practicable; (D) serve as a member of Council and as Chairman of the Executive Committee; (E) serve as a member of all committees of the Association with the authority to call a meeting of any board or committee when necessity demands it or after failure of the chairman to do so. With the approval of Council, he may terminate any committee whose function has been fulfilled or replace any member of any committee who fails to show interest in performing the duties assigned to him, and (F) he shall be an ex-officio member of the House of Delegates without the right to vote.

CHAPTER VI. RIGHTS AND DUTIES OF OFFICERS. SECTION 3. THE VICE PRESIDENTS, at present reads:

The Vice Presidents shall be members of the Council. The Vice Presidents shall assist the President in the discharge of his duties. Upon request or in the absence of the President, the Vice Presidents will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice Presidents, in their order shall succeed him for the unexpired term. The Vice Presidents shall be ex-officio members of the House of Delegates without the right to vote.

CHAPTER VI. RIGHTS AND DUTIES OF OFFICERS. SECTION 3. THE VICE PRESIDENTS, as amended shall read:

The Vice Presidents shall be members of the Council. The Vice Presidents shall assist the President in the discharge of his duties. The First Vice President shall be an ex-officio member of the Executive Committee, and shall attend all meetings. If he is unable to attend any meeting of the Executive Committee, the Second Vice President shall be notified to attend in his stead. The Vice President shall not have the privilege to vote, except in case of death of the President or his incapacity as determined by the Council upon the recommendation of the Executive Committee. Upon request or in the absence of the President, the Vice Presidents will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice Presidents in their order shall succeed him for the unexpired term. The Vice Presidents shall be ex-officio members of the House of Delegates without the right to vote.

CHAPTER IX. STANDING COMMITTEES. SECTION 1, at present reads:

The Standing Committees of the Association shall be as follows:

- (A) *Committee on Legislation*
- (B) *Committee on Medical Education*
- (C) *Committee on Medical Defense*
- (D) *Committee on Professional Conduct*
- (E) *Committee on History and Vital Statistics*
- (F) *Committee on Public Health*
- (G) *Committee on Maternal and Infant Welfare*
- (H) *Committee on Rural Health*
- (I) *Committee on Industrial Health*
- (J) *Committee on Public Service*
- (K) *Committee on Cancer*
- (L) *Committee on Insurance and Economics*
- (M) *Committee on Veterans Affairs*
- (N) *Committee on Constitution and Bylaws*
- (O) *Committee on Scientific Exhibit Awards*
- (P) *Committee on Woman's Auxiliary*
- (Q) *Committee on Hospital Relations*
- (R) *Committee on Crawford W. Long Memorial*
- (S) *Committee on Mental Health*
- (T) *Committee on Geriatrics*

CHAPTER IX. STANDING COMMITTEES. SECTION 1, as amended shall read:

CHAPTER IX. COMMITTEES. SECTION 1. The The Committees of the Association shall be as follows:

- (A) Executive Committee of Council
- (B) Committee on Finance
- (C) Committee on Professional Conduct
- (D) Committee on Woman's Auxiliary

CHAPTER IX. SECTION 2, at present reads:

Unless otherwise provided in these Bylaws, each of these committees shall consist of three members, each of whom shall serve for three years. Unless otherwise provided in these Bylaws, Executive Committee of Council shall appoint standing committee members and standing committee chairmen as needed. One member of each standing committee shall be appointed each year by the Executive Committee of Council to serve for three years. The Executive Committee shall make all appointments at least thirty days prior to the annual session and all standing committees shall hold their organizational meeting at the time of the Annual Session. The members of each committee shall serve staggered terms of office so that only one term shall expire each year. The President, with the approval of Council, may replace any member of any committee who fails to show interest in performing the committee duties assigned him. All committee chairmen shall make an annual report in writing to the Association headquarters office sixty days in advance of the Annual Session for consideration by the House of Delegates.

CHAPTER IX. SECTION 2, as amended shall read:

- (A) Executive Committee of Council (See Chapter IV., Section 3)
- (B) Committee on Finance (See Chapter IV., Section 9)
- (C) Committee on Professional Conduct:

The Committee on Professional Conduct shall consist of the five most recent living Past Presidents of the Association. The senior member shall be chairman. It shall investigate all complaints relating to or involving the ethical or professional practice of any member of the Medical Association of Georgia. All complaints or accusations against any member of the Medical Association of Georgia relative to irregular practice, excessive fees, habitual failure to respond to calls without adequate reason, extravagant or questionable statements made as witnesses in a court of law, or any act calling for disciplinary measures or investigations of a member, shall become the concern of this committee. Complaints may be made by an individual patient, physician, board of censors of any local medical society, attorney, or any officer of a regularly constituted court of law. Upon receipt of notice of such complaint, the committee, through its individual members or some competent person designated by it, shall immediately investigate the charges, and if the committee is convinced that there is sufficient justification for a hearing, the physician shall be requested to appear before at least three members of said committee to answer charges. Such hearing shall be conducted in private and the source of information and charges will be divulged only at such hearing. No member of this committee shall sit in a hearing involving a physician from his councilor district.

After deliberation, the committee shall have a choice of one of the four following dispositions:

- (1) Dismiss the case because of insufficient grounds for a legitimate complaint.
- (2) Attempt a satisfactory adjudication of the complaint.
- (3) Suggest to the physician changes in his conduct and relationship with his patients, in order that he may not bring unfavorable criticism upon his profession.

(4) Refer to the Council of The Medical Association of Georgia all cases in which action by the Council is deemed necessary, together with recommendations as to disciplinary measures to be taken by the Council of the Medical Association of Georgia.

Nothing in this Bylaw shall be construed to prevent the selection and active participation in all the functions enumerated above by each component county society.

- (D) Committee on Woman's Auxiliary:
The Committee on the Woman's Auxiliary shall cooperate with, advise, and direct the Auxiliary in all matters concerning the Association.

CHAPTER IX. SECTION 3. (A) through (T) will be deleted and in place of them will be inserted the following:

CHAPTER IX. SECTION 3. SPECIAL COMMITTEES AND LIAISON APPOINTMENTS.

Special Committees may be created at any time when the necessity arises. Their necessity must be approved by the Council and they shall be appointed by the President. Special Committees shall be appointed annually and the term of office shall

run concurrent with that of the appointing President.

Members of Association serving as liaison representatives of Association on joint committees with other organizations shall be appointed by the President with the approval of the Executive Committee and shall report back at least once a year to the Council.

CHAPTER X. SPECIAL COMMITTEES AND EXECUTIVE SECRETARY, as amended shall read:

CHAPTER X. BOARDS. SECTION 1.

The Boards of the Association shall be as follows:

- (A) Medical Education
- (B) Hospital Activities
- (C) Governmental Medical Services
- (D) Volunteer Health Agencies
- (E) Occupational Health
- (F) Interprofessional Relations
- (G) Public Service
- (H) Legislation
- (I) Insurance and Economics
- (J) Constitution and Bylaws
- (K) Annual Session
- (L) Special Activities

SECTION 2.

The Boards of the Association shall consist of not less than five (5), or more than fifteen (15) members, as determined by Council. One member of Council shall be a member of each board to maintain proper liaison. Appointment to the boards shall be made by the Executive Committee, subject to approval of Council. Appointments shall be made within thirty days after the Annual Session. Terms of appointment shall be staggered and for a three (3) year period, so that one third of each board is appointed each year.

All board action and activities shall be reported to Council. An annual report of board activities shall be made in writing by the Chairman at least 60 days preceding the Annual Session. The Annual Report will be transmitted to the House of Delegates, with report of Council action or recommendation, if any. Such ex-officio members of each board may be appointed by the President with the consent of the Executive Committee and the approval of Council as deemed necessary. No ex-officio member shall have the power to vote unless otherwise provided by Council.

The Chairman of the Board, with the consent of the Executive Committee, may appoint Sub-Committees for the study and investigation of special problems. Reports and recommendations of such Sub-Committees shall be presented to the entire board before the findings are passed on to the Council.

SECTION 3. (A) MEDICAL EDUCATION

The Board of Medical Education shall act as an advisory body on matters of medical education, undergraduate and postgraduate, and the education and training of paramedical personnel. All matters regarding medical education shall be referred to this Board. The Board shall consider and devise

means of extending the educational work of the Association. It shall work with and assist component county societies, in the development of their education programs. The Board shall serve for the Council on Medical Education of the American Medical Association in this state.

SECTION 3. (B) HOSPITAL ACTIVITIES

The Board on Hospital Activities shall pursue a continuing study and investigation of the relations of the medical profession to all hospitals in the State and make recommendations to the Association. The Board shall maintain contact and confer with the Georgia Department of Public Health, Georgia Hospital Association, and related organizations dealing with hospitalization. The Board shall pursue a continuing study and program of the development of standards and accreditation of hospitals, nursing homes and the other similar or related institutions.

SECTION 3. (C) GOVERNMENTAL MEDICAL SERVICES

The Board on Governmental Medical Services shall study and make recommendations to Council concerning public health or any governmental activity involving medical practice unless otherwise designated by Council.

SECTION 3. (D) VOLUNTEER HEALTH AGENCIES

The Board of Volunteer Health Agencies shall study and evaluate the programs of the various volunteer health agencies. The Board shall make recommendations concerning the programs and activities of the various agencies to Council.

SECTION 3. (E) OCCUPATIONAL HEALTH

The Board of Occupational Health shall confer with labor, management, and agricultural organizations, stressing the importance of preventive rather than curative medicine. The Board shall investigate and make recommendations concerning the initiation of programs designed to improve working conditions for all those employed in industry, farming, mining, and other occupations. The Board will be available for conference with the Compensation Board, Farm Groups, and also the councils on Rural Health and Industrial Health of the American Medical Association and other related groups.

SECTION 3. (F) INTERPROFESSIONAL RELATIONS

The Board of Interprofessional Relations shall study the problems of medical practice, which involve other professional groups. The Board will make recommendations to the Association concerning existing problems. At the request of Council, the Board will confer with and endeavor to arrive at a solution of problems involving other professions.

SECTION 3. (G) PUBLIC SERVICE

The Public Service Board shall study and consider existing and proposed policies of the Association. It shall develop projects for better under-

standing between physicians and the public. The Board will make recommendations to Council in any matter affecting public relations. It shall integrate and publicize all approved plans and projects emanating from Council and the House of Delegates.

SECTION 3. (H) LEGISLATION

The duty of the Legislative Board shall be to represent the Association as directed by Council in the interest of public health and scientific medicine.

SECTION 3. (I) INSURANCE AND ECONOMICS

The Insurance and Economics Board shall investigate and make recommendations to the Association, concerning all insurance and economic problems involving medical care and medical practice. The Board will initiate and supervise such insurance or economic policies, as are approved by Council.

SECTION 3. (J) CONSTITUTION AND BYLAWS

The duty of the Constitution and Bylaws Board shall be to study the organization of the Medical Association of Georgia. It shall recommend to the House of Delegates, through Council, any amendments or revisions, which seem necessary or advisable. At least every five years, the Board shall recommend revisions after a complete study of the organization. Proposed amendments shall be referred to this Board for recommendation, before action is taken by the House of Delegates.

SECTION 3. (K) ANNUAL SESSION

The Annual Session Board shall carry out the approved policies of the Association, as directed by Council. It shall study and make recommendations concerning the Annual Sessions of the Association. The Board shall submit an Annual Session Budget to the Finance Committee of the Association.

The Board Sub-Committee on Scientific Exhibits and Awards shall have supervision of all scientific exhibits and awards made by or in the name of the Association for scientific exhibitors at the Annual Session.

SECTION 3. (L) SPECIAL ACTIVITIES

The Board of Special Activities shall study such problems as are referred to it by the Association. The Board shall make recommendations to the Association, and when approved, it will initiate and carry out any policy or activity as directed by Council.

CHAPTER X. SPECIAL COMMITTEES AND EXECUTIVE SECRETARY, shall be renumbered CHAPTER XI.

CHAPTER XI. THE JOURNAL. SECTION 1, at present reads:

The Journal of the Medical Association of Georgia herein referred to as The Journal, shall be under the control and direction of the Council. It

shall appoint an Editor and an Editorial Board annually and make any other provisions for the publication of The Journal; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

SECTION 2.

The Council may employ a Business Manager of The Journal and other personnel and fix the terms of such employment.

SECTION 3.

All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in The Journal.

Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

SECTION 4.

The Executive Committee of the Council shall constitute the Publications Committee of the Journal.

CHAPTER XI, as amended shall read as follows:

CHAPTER XII. THE JOURNAL

The Journal of the Medical Association of Georgia herein referred to as The Journal, shall be under the control and direction of the Council. It shall appoint an Editorial Board annually and make any other provisions for the publication of The Journal; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

SECTION 2.

All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in The Journal. Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

SECTION 3.

The Executive Committee of the Council shall constitute the Publications Committee of The Journal.

CHAPTER XII. RULES AND ETHICS, shall be renumbered CHAPTER XIII.

CHAPTER XIII. AMENDMENTS, shall be renumbered CHAPTER XIV.

CHAPTER XIV, shall be renumbered CHAPTER XV.

REFERENCE COMMITTEE RECOMMENDATION — This report was approved with the additional recommendations:

(1) In Chapter VI, Section 3, The Vice President — Add: "The Second Vice President shall succeed to the office of First Vice

President upon the occasion of succession of the President-Elect to the office of President."

This Committee takes cognizance of the increasing complexity of the duties of the President and of his need for trained assistants. For this reason, it is felt that the Vice President should take a more active part in and be better informed of the activities of the Association. To this end, it is recommended that the tradition that the Chairman of the Local Arrangements Committee be automatically nominated to the office of First Vice President be discontinued.

(2) In Chapter X, this section should read: CHAPTER X. Re-number CHAPTER XI and designated Executive Secretary. Section 1 of the previous Bylaws is deleted and Section 2 of the previous Bylaws becomes Section 1.

This Committee wishes particularly to commend Dr. Thomas W. Goodwin and the members of his Committee for their efforts in a most difficult job.

HOUSE OF DELEGATES ACTION—Adopted the Supplementary Report of the Constitution and Bylaws Committee No. B: Committee Reorganization with the additional recommendations of the Reference Committee as recommended by the Reference Committee on motion duly made and seconded.

It was moved by the Chairman of Reference Committee No. 3, Leo Smith, Waycross, and duly seconded that the report of Reference Committee No. 3 be approved as a whole and it was so ordered.

Report of Reference Committee No. 4
P. K. Dixon, M.D., Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 4 met at 2:30 P.M., May 8, 1961, in Room 1007, Biltmore Hotel, Atlanta, Georgia. Members of this Committee present were: P. K. Dixon, Gainesville, Chairman; William E. Coleman, Hawkinsville, Vice Chairman; Harry Brill, Columbus, Secretary; F. N. Harrison, Augusta; Irving L. Greenberg, Atlanta; H. Hilt Hammett, Jr., LaGrange; J. W. Yeomans, Jesup (For R. A. Pumphelly, Jesup), and Lester Rumble, Atlanta.

THIRD DISTRICT COUNCILOR
W. G. ELLIOTT, M.D., Cuthbert

The Third District has eight organized societies. The Muscogee Society is very active and meets monthly, has very good programs, and is well attended. Excellent bulletins are published monthly. There are over 100 members in this Society. For the past two years the fall meeting of the Third District Medical Society is held in conjunction with the outstanding fall meeting of the Muscogee Society. It has been quite successful. The Sumter County Society is quite active and meets monthly, except during the summer months.

The Flint Society is quite active, meets regularly, and has good programs.

The Peach Belt Society is quite active and is second in size in the District. The programs are good and well attended.

The other four societies are relatively inactive, and

are rather small, and I have not been able to get much information about their activities.

I have asked all the Societies to let me know the date of their meetings, and the smaller ones have not done this, so I have not attended their meetings.

I have had the pleasure of presenting a Certificate of Appreciation to two of our Third District Societies for their 100 per cent participation in American Medical Education Foundation contribution for 1959. These were Muscogee County Society and Peach Belt Society. These Societies are to be congratulated. I have served as Councilor for the Third District for 15 years. Last fall at the Third District Meeting I asked the Society to nominate someone else, as I felt I had served long enough in this capacity. A good man was nominated, and I feel he will carry on the Councilor work for our District, and do a better job than I have been able to do.

I have enjoyed my 15 years of service.

Counties and Secretaries	Members December 31, 1960		Members December 31, 1959	
	MAG	AMA	MAG	AMA
Ben Hill-Irwin				
W. C. Sams				
Ocilla	8	7	8	7
Flint				
J. W. Reynolds				
Ashburn	16	13	16	15
Peach Belt				
V. J. Grantham				
Ft. Valley	24	21	21	19
Muscogee				
Bruce Newsom				
Columbus	104	97	104	100
Ocmulgee				
Blake S. Bivins				
Cochran	13	10	13	10
Randolph-Terrell				
R. B. Martin, III				
Cuthbert	11	9	10	8
Sumter				
Frank Wilson, III				
Leslie	22	20	18	17
Taylor				
E. C. Whatley				
Reynolds	5	1	5	2
	203	178	195	178

REFERENCE COMMITTEE RECOMMENDATION—This Committee accepts and approves the report of the Third District Councilor with the following addendum offered by William E. Coleman:

The Ocmulgee County Medical Society holds active regular quarterly meetings.

This Committee further recommends commendation for the Muscogee County and Peach Belt Societies for their 100 per cent participation in the American Medical Education Foundation contributions. This Committee wishes to commend Dr. W. G. Elliott, not only for his activities during the past year, but for 15 years of excellent and faithful service as Third District Councilor.

HOUSE OF DELEGATES ACTION—Adopted the report of the Third District Councilor with the additional recommendations as recommended by the Reference Committee on motion duly made and seconded.

FOURTH DISTRICT COUNCILOR

VIRGIL B. WILLIAMS, M.D., *Griffin*

The Councilor of the Fourth District has attended all regular and called meetings of the Council during the past year.

During the year the Councilor has remained in contact with activities of all societies in his district. Informal consultations have been held with members of the association residing in the Fourth District. Matters concerning policy, organizations, and ethics have been observed closely by the Councilor.

During the year it has been the pleasure of the Councilor to protect the interest of and aid in the betterment of the component societies in the Fourth District.

The Councilor has been ready at all times to advise on problems pertaining to the office.

Counties and Secretaries	Members December 31, 1960		Members December 31, 1959	
	MAG	AMA	MAG	AMA
Clayton-Fayette				
Wells Riley				
Jonesboro	5	5	5	5
Coweta				
E. E. Proctor, Sr.				
Newnan	18	8	17	6
Lamar				
S. B. Traylor				
Barnesville	4	4	4	4
Meriwether-Harris				
J. W. Smith, Jr.				
Manchester	14	7	14	7
Newton				
J. W. Purcell, Jr.				
Covington	12	10	11	10
Spalding				
I. H. Slade, Jr.				
Griffin	41	37	37	34
Troup				
J. T. Mitchell				
LaGrange	43	36	42	35
Upson				
J. H. Woodall				
Thomaston	15	13	16	12
	152	120	146	113

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Fourth District Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Fourth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

FIFTH DISTRICT COUNCILOR

J. G. McDANIEL, M.D., *Atlanta*

Your Councilor from the Fifth District has had a busy year. I was reelected Chairman of Council. I have attended all meetings of the Council and the Executive Committee.

The Fifth District meeting was a great success. It

was well attended. Dr. J. Lawrence Pool, Professor of Neurological Surgery, Columbia University, presented an outstanding paper on the subject "The Diagnosis and Treatment of Intracranial Bleeding."

The District is growing, as may be noted in the report attached. The chances are that Fulton will have 1,000 members and DeKalb, 100 members, by next year. Both have wide-awake and progressive societies.

The Vice-Councilor, Dr. Charles Jones, continues to do an outstanding job. He attends the meetings faithfully and has rendered yeoman's service as Vice Chairman of the Insurance and Economics Committee.

Counties and Secretaries	Members December 31, 1960		Members December 31, 1959	
	MAG	AMA	MAG	AMA
DeKalb				
James Anthony				
Decatur	93	82	88	78
Fulton				
T. J. Anderson, Jr.				
Atlanta	917	730	910	731
	1,010	812	998	809

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Fifth District Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Fifth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

SIXTH DISTRICT COUNCILOR

GEORGE H. ALEXANDER, M.D., *Forsyth*

Your Councilor has attended all of the regular and called meetings of council which have been held during the year.

Your Councilor has submitted his resignation to the President of the Sixth District Society as Councilor. The resignation to become effective at the 1961 Annual Session of MAG. This resignation was submitted in accordance with plans for reorganization of Council as approved by Council at its June meeting in Macon.

The Sixth District Medical Society met in Macon at the Town Pavilion Motel for its December 1960 meeting and an excellent program was presented.

The following officers were elected for 1961: President, Dr. Walter Bramblett, Forsyth; Vice President, Dr. J. J. Pilcher, Wrens; Secretary-Treasurer, Dr. Hugh Sealy, Macon.

Dr. William Rawlings of Sandersville was nominated by the Society to fill the unexpired term as Councilor which resulted from the resignation of your present Councilor as noted above.

Dr. John Bell of Dublin was nominated to fill the unexpired term of Dr. W. H. M. Weaver of Macon who also resigned as noted above.

It has been a great deal of pleasure to serve as Councilor of the Sixth District and it is my hope that all constituent societies will cooperate fully with the new Councilor and Vice Councilor.

Counties and Secretaries	Members December 31, 1960		Members December 31, 1959	
	MAG	AMA	MAG	AMA
Baldwin				
E. W. Allen				
Milledgeville . . .	31	18	35	17
Bibb				
John T. Dupree				
Macon	154	140	154	136
Jasper				
E. M. Lancaster				
Shady Dale . . .	3	2	4	3
Jefferson				
John J. Pilcher				
Wrens	7	4	8	2
Laurens				
Quentin Price				
Dublin	28	14	35	12
Washington				
William Rawlings				
Sandersville . . .	11	—	11	—
	<hr/>	<hr/>	<hr/>	<hr/>
	234	178	247	170

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Sixth District Councilor and commends him for his activities during the year and for his previous years of service.

HOUSE OF DELEGATES ACTION — Adopted the report of the Sixth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

MENTAL HEALTH

R. J. VAN DE WETERING, M.D., *Chairman*

During the past year the members of the Mental Health Committee have continued their participation in various mental health groups, movements, and committees throughout the State. The Committee as a whole has completed its investigation into the actuarial experience of health insurance coverage of emotional illness and is moving toward liaison with the local Blue Cross in an attempt to provide this type of insurance coverage in Georgia. The Mental Health Page of the *Journal of the Medical Association of Georgia* under the editorship of Dr. Richard Felder has continued to print monthly papers of a useful and practical nature. We hope to continue this policy in the future.

During the past year there has been investigation into the experience in other states in developing mental health programs within student health programs in the state universities and colleges. It is a project which will continue to interest the Committee and to which investigation will be continued.

Planned for the coming year is a revision of the booklet, "Hospitalization of the Mentally Ill in Georgia."

The Chairman of the Mental Health Committee participated in the annual conference of Chairmen of Mental Health Committees in Chicago during the month of January. This was again a most productive conference and the proceedings will soon be available to the Association for study and action, since there are several areas which are especially applicable to the State of Georgia.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of R. J. Van de Wetering and his Committee on Mental Health.

HOUSE OF DELEGATES ACTION — Adopted the report of the Mental Health Committee as recommended by the Reference Committee on motion duly made and seconded.

PROFESSIONAL CONDUCT

WILLIAM HARBIN, M.D., *Chairman*

It is gratifying that during the past year the Professional Conduct Committee has had no work to do. There have been no matters which have required action by this Committee and it is hoped that the Association will be as fortunate next year.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of William Harbin and his Committee on Professional Conduct.

HOUSE OF DELEGATES ACTION — Adopted the report of the Professional Conduct Committee as recommended by the Reference Committee on motion duly made and seconded.

PUBLIC HEALTH

VIRGIL B. WILLIAMS, M.D., *Chairman*

The Public Health Committee has held no formal meetings during the year. However, the Chairman and the Committee have maintained close liaison with the Georgia State Department of Public Health. It is felt that as a result of this relationship there is a close correlation of interests and activities between the Medical Association of Georgia and The Georgia Department of Public Health.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves with commendation the report of Virgil Williams and his Committee on Public Health.

HOUSE OF DELEGATES ACTION — Adopted the report of the Public Health Committee as recommended by the Reference Committee on motion duly made and seconded.

MEDICAL CIVIL PREPAREDNESS

E. M. DUNSTAN, M.D., *Chairman*

The activities of this Committee for the year 1960-1961 may be summarized as follows:

1. Continued in an advisory capacity to the Georgia Civil Defense Health Services on medical civil defense matters. Constant liaison is maintained through Dr. Lester M. Petrie, Deputy Director of the Georgia Civil Defense Health Services.

2. Participated in the coordination activities of the Implementation Committee for Region III (Southeastern states) of O.C.D.M.

3. Participated in the fifth year of instruction in the Course on Catastrophic Injuries and Diseases instituted by the Emory University School of Dentistry as a regular course for senior dental students.

4. Participated in a conference of leading Georgia Civil Defense leaders where the new Medical Self-Help Training Kit was demonstrated and plans discussed for

intensification of statewide instruction in this connection.

5. Participated in the conference which led to decision to begin in January, 1961, the Census of Health Manpower Personnel throughout Georgia. Members of the Committee, particularly Dr. Charles Dowman, have been urging that this be done for some years, and now it is a reality. Participating statewide groups include, in addition to the Medical Association of Georgia and its Auxiliary: community hospital administrators, state, regional, district, and local health departments, State Department of Labor, Selective Service boards, and, of course, State Civil Defense Headquarters. Medical participation will be spearheaded by Mrs. Kels Boland, ex-officio member of our Committee from the Medical Auxiliary, and she and her staff will get help from local Parent-Teacher Associations for this canvass. We wish to express again our deep appreciation, through Mrs. Kels Boland, to the Woman's Auxiliary for this great contribution.

Recommendations

The Committee recommends that:

1. The composition of the Medical Civil Preparedness Committee continue as at present, namely, one member from each of the six key civil defense areas of the State together with any other members-at-large that the President may wish to appoint.

2. The advisory and coordinating functions of the Committee continue as in the past.

3. Full statewide cooperation be given the Medical Self-Help Training Section of the U.S. Public Health Service in their efforts to give nationwide instruction with the aid of the Medical Self-Help Training Kit. This recommendation is in accordance with the official position of the American Medical Association as stated in its Report on National Emergency Medical Care: "The population of the United States should be prepared for mass casualty conditions by a civil defense program of self aid and medical training."

4. Full cooperation continued to be given community hospital administrators, regional, district, and local health departments, and other organizations mentioned above, in their census of health manpower personnel. The accomplishment of this vital task should make possible early institution of practice runs for simulated major disasters in the main cities of Georgia. In this connection it is recommended that the memorandum on Health Manpower Mobilization from Dr. Lester M. Petrie, which is available from the Committee, be distributed by the Medical Association of Georgia Headquarters to all local medical societies with the request that they make suggestions for improvements.

5. The Deputy Director of Georgia Civil Defense Health Services be made an ex-officio member of this Committee in order to make liaison still more effective.

6. The name of this Committee be changed, in compliance with the wishes of the AMA Department of National Security, from Civil Defense Preparedness to the Committee on Disaster Medical Care.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of E. M. Dunstan and his Committee on Medical Civil Preparedness with one change recommended in line two of the recommendation No. 5 as follows:

"That the words 'be invited to be' be substituted for 'be made'."

(Paragraph No. 4 of the Supplementary Report of the President No. A: Health Care of the Aging, was referred to this Reference Committee and reads as follows):

"During the past year we have shown some complacency toward civil defense in case this country should be bombed or attacked by outside enemies. It is the feeling of your President that our civilian defenses and measures for emergency treatment of disaster victims should be reevaluated and our position of cooperation be reaffirmed, for it now appears as though a disastrous attack from outside enemies is more of a reality than it has ever been in the past history of this country."

(Reference Committee No. 4 recommendation on this matter follows):

Furthermore, this Committee accepts and approves paragraph No. 4 of the Supplementary Report of the President Milford B. Hatcher, which also relates to civil defense.

HOUSE OF DELEGATES ACTION — Adopted the report of the Medical Civil Preparedness Committee as amended by the Reference Committee and also adopted paragraph No. 4 of the Supplementary Report of the President No. B, which also relates to civil defense as recommended by the Reference Committee on motion duly made and seconded.

WEEKLY HEALTH COLUMN

AUGUST S. YOCHER, M.D., *Chairman*

The Weekly Health Column Committee was appointed in 1958 and is now in its third year of activity. The Committee has met often during the past year and has prepared 51 articles for publication. These articles have been of a popular interest and have concerned various diseases, conditions, and situations related to medical and health care.

Of the 197 weekly newspapers in Georgia, about 125 have published "Doc MAG Says" one or more times. The Health Column is mailed only to weekly newspapers. "Doc MAG Says" has been published in 111 counties in Georgia out of the 148 which have weekly newspapers.

The Committee is indebted to the professional writer who assists in editing the columns. This writer is paid a modest amount for these services.

Your Chairman recommends continuance of this project in the interest of serving the citizens of Georgia by keeping them informed about medical subjects of interest. Each local medical society is encouraged to inform and stimulate their local weekly newspaper publisher to take advantage of this MAG service.

I wish to thank the members of the Council and the Finance Committee for their interest and support in this important project. I also wish to commend all of the members of the Committee who worked so diligently during the year.

The members of the committee representing most of the medical specialties and general practice are as follows: August S. Yocher, Jr., Atlanta, Chairman; C. J. Wyatt, Jr., Rome; Robert C. Garner, Atlanta; Lamar F. Glass, Atlanta; Jule C. Neal, Macon; E. P. Inglis, Marietta; Ben H. Jenkins, Newnan; Jesse Denny Hall, Jr., Griffin, and Ferrol A. Sams, Jr., Fayetteville.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves with commendation the report of August S. Yocher and his Committee on Weekly Health Column.

The Committee further recommends that the Weekly Health Column be forwarded to daily, as well as weekly, newspapers and that those weekly newspapers which are not carrying the column be contacted again.

HOUSE OF DELEGATES ACTION — Adopted the report of the Weekly Health Column Committee with the additional recommendation of the Reference Committee as recommended by the Reference Committee on motion duly made and seconded.

Resolution No. 5

ESTABLISHMENT OF BURN CENTER

OCONEE VALLEY MEDICAL SOCIETY

Whereas, the past history of burned cases in the rural sections of our State show that a large percentage of them are indigent and of the poorer class of people, who are unable to adequately pay for the treatment of such cases, and also that the treatment of such cases is usually long, drawn out, and very expensive. Therefore, such cases are generally treated at a loss by the hospitals and the medical profession; and

Whereas, there are "centers" in Georgia for the treatment of indigent tuberculosis and venereal disease patients; and

Whereas, in our opinion it is just as important for an indigent burned person to be adequately treated as are those with tuberculosis and venereal disease;

Now, therefore, be it resolved, that a burn center be established in the State of Georgia principally for the treatment of indigent burned cases.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves Resolution No. 5: Establishment of a Burn Center and recommends that Council appoint a special committee to further study the problem and make a report and recommendation to Council.

HOUSE OF DELEGATES ACTION — Adopted Resolution No. 5: Establishment of a Burn Center as recommended by the Reference Committee on motion duly made and seconded.

It was moved by the Chairman of Reference Committee No. 4, P. K. Dixon, Gainesville, and duly seconded that the report of Reference Committee No. 4 be approved as a whole and it was so ordered.

Report of Reference Committee No. 5

John T. Godwin, M.D., Chairman

(The following reports as presented to this Reference Committee are printed in full with the Reference Committee's recommendations and the action pursuant to it taken by the House of Delegates.)

Reference Committee No. 5 met at 2:30 p.m., May 8, 1961, in Room 1011, Biltmore Hotel, Atlanta, Georgia. Members present were: John T. Godwin, Atlanta, Chairman; J. B. Bowen, Augusta, Vice Chairman; J. I. Vansant, Villa Rica, Secretary; Shelley C. Davis, Atlanta; T. A. Sappington, Thomaston; E. C. McMillan, Jr., Macon, and Harold Engler, Augusta.

SEVENTH DISTRICT COUNCILOR

RALPH W. FOWLER, M.D., Marietta

The Seventh District Medical Society has had a satisfactory year since the last annual meeting of the Medical Association of Georgia.

The semiannual meetings were held on the last Wednesday of September and first Wednesday of April.

These meetings had excellent programs with speakers from our own District and from outside areas. They were well attended both by members and their wives in the Auxiliary.

Much interest has been shown in the support of the American Medical Educational Foundation. At the fall meeting Certificates of Commendation from A.M.E.F. were presented to six counties in the Seventh District whose memberships had contributed 100 per cent to the Fund. It is hoped this year we may get 100 per cent of our whole membership.

A special effort was made to get representatives from the various counties in the District to attend the December instruction meeting for new officers of County Societies at MAG Headquarters. This was largely successful.

During the year members of the District have been very helpful in contacting legislators, both State and national, on the various issues of such vital importance to our profession. The Woman's Auxiliary members have also been most helpful in this endeavor.

Our membership has shown an encouraging increase.

Counties and Secretaries	Members December 31, 1960		Members December 31, 1959	
	MAG	AMA	MAG	AMA
Bartow				
Virginia D. Hamilton				
Cartersville	8	7	9	6
Carroll-Douglas-Haralson				
J. H. Beall				
Carrollton	33	26	35	28
Chattooga				
G. H. Little				
Trion	7	7	6	5
Cobb				
Noah D. Meadows, Jr.				
Marietta	81	74	72	68
Floyd				
Robert J. Black				
Rome	58	49	57	50
Gordon				
Charles K. Richards				
Calhoun	9	7	10	7
Polk				
Charles M. Smith				
Rockmart	13	10	13	10
Walker-Catoosa-Dade				
Leroy Sherrill				
Rossville	30	25	30	24
Whitfield				
Sidney L. Sellers				
Dalton	37	23	29	18
	276	228	261	216

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Seventh District Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Seventh District Councilor as recommended by the Reference Committee on motion duly made and seconded.

EIGHTH DISTRICT COUNCILOR

F. G. ELDRIDGE, M.D., Valdosta

Your Councilor attended all meetings of Council during the past year.

The larger societies in the District are very active and meet regularly and have good programs.

The District Society holds two regular meetings each year, the second Tuesday in October and April; these meetings are fairly well attended and good programs are given. Attendance varies in accordance with meeting places as the District is rather large and measures some 130 miles by 90 miles. The meetings held in the central areas are better attended than those in the marginal areas.

Counties and Secretaries	Members December 31, 1960		Members December 31, 1959	
	MAG	AMA	MAG	AMA
Altamaha				
Horace L. Morgan				
Baxley	7	6	—	—
Coffee				
C. S. Meeks, Jr.				
Douglas	13	6	13	6
Glynn				
C. A. Wilson				
Brunswick	45	40	45	42
South Georgia				
J. Miller				
Valdosta	51	45	50	43
Telfair				
D. B. McRae				
McRae	8	6	8	6
Ware				
Henry Adkins				
Waycross	49	39	50	40
Wayne				
Fred Harper				
Jesup	8	8	8	8
	181	150	181	152

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Eighth District Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Eighth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

EIGHTH DISTRICT VICE-COUNCILOR

JAMES M. HICKS, M.D., Brunswick

Projects of the Glynn County Medical Society

Continuation and development of a successful heart program was achieved. This included classes for nurses and hospital personnel. Open heart surgery was continued, new hypothermia units constructed, and a new intracardiac electrode perfected. A stroke rehabilitation program instituted.

A program on resuscitation was sponsored by the Medical Society. An excellent film on mouth-to-mouth breathing was purchased and shown to all the schools,

PTA's, civic clubs, fire departments, and ambulance attendants and in down-town theaters.

A Hospital Authority Board was acquired by a public education program through radio and newspaper coverage and talks before all of the civic clubs.

Cards were placed in the physicians' offices inviting discussion of fees.

Projects in View

Public educational campaigns on what to do in emergencies of all types were held.

Close liaison with our schools was maintained. Physicians were assigned to each school to aid in utilizing news for instruction or educational aid.

Better use of the physician in physical examinations of the school athletes was made.

A high school organization known as the "Future Medics" was given an instructional tour through our hospital.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Eighth District Vice Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Eighth District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

NINTH DISTRICT COUNCILOR

C. R. ANDREWS, M.D., Canton

I consider it an honor and privilege to continue to serve as Councilor for the Ninth District during the current year. Dr. Scoggins has continued to do an excellent job as the Ninth District Vice-Councilor. All Council meetings have had Ninth District representation.

At the Ninth District meetings which are held twice a year, in April and September, an excellent scientific program has been prepared and is presented in a very interesting manner. Our District meetings are well attended.

Overall membership is about the same as in the past. Listed below is a breakdown of the eight county societies and their membership.

Counties and Secretaries	Members December 31, 1960		Members December 31, 1959	
	MAG	AMA	MAG	AMA
Blue Ridge				
Thomas J. Hicks				
McCaysville	9	5	12	10
Chattahoochee				
George S. Tootle				
Duluth	20	17	19	17
Cherokee-Pickens				
D. T. Darnell				
Canton	14	11	15	11
Habersham				
Don C. Fahrback				
Cleveland	16	15	16	14
Hall				
C. J. Walker, Jr.				
Gainesville	48	43	46	38

Jackson-Barrow				
A. A. Rogers, Jr.				
Commerce . . .	17	12	17	12
Rabun				
J. C. Dover				
Clayton . . .	3	2	5	4
Stephens				
Robert E. Thompson				
Toccoa . . .	17	14	16	13
	<u>144</u>	<u>119</u>	<u>146</u>	<u>119</u>

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Ninth District Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Ninth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

NINTH DISTRICT VICE-COUNCILOR

PAUL T. SCOGGINS, M.D., *Commerce*

I attended all Council meetings with one exception. The Ninth District was represented at all Council meetings.

The report of the District will be given by Dr. Andrews, Councilor.

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Ninth District Vice Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Ninth District Vice Councilor as recommended by the Reference Committee on motion duly made and seconded.

TENTH DISTRICT COUNCILOR

A. W. SIMPSON, M.D., *Washington*

As Councilor for the Tenth District of the Medical Association of Georgia, I wish to report a very successful year for our District. The Tenth District Society held two meetings with outstanding scientific programs; the summer meeting in Athens, the winter meeting in Augusta.

I attended all but one meeting of the Council and was ably represented at this meeting by Dr. Marion Hubert, Vice-Councilor.

All component societies have been active, holding regular scientific meetings and participating in our legislative efforts.

Counties and Secretaries	Members December 31, 1960		Members December 31, 1959	
	MAG	AMA	MAG	AMA
Crawford W. Long				
Augustus B. Boyd				
Athens . . .	49	40	43	37
Franklin-Hart-Elbert				
Louis G. Cacchioli				
Hartwell . . .	23	17	24	15

McDuffie				
Ernest L. Cook				
Thomson . . .	6	6	8	8
Oconee Valley				
Kendrick Lewis				
Sparta . . .	13	9	12	9
Richmond				
F. N. Harrison				
Augusta . . .	222	183	220	186
Walton				
Stevens Byars				
Monroe . . .	12	10	10	9
Warren				
A. W. Davis				
Warrenton . . .	2	1	2	1
Wilkes				
Harry Cheves				
Union Point . . .	11	7	11	8
	<u>338</u>	<u>273</u>	<u>330</u>	<u>273</u>

REFERENCE COMMITTEE RECOMMENDATION — This Committee accepts and approves the report of the Tenth District Councilor and commends him on his activities during the year.

HOUSE OF DELEGATES ACTION — Adopted the report of the Tenth District Councilor as recommended by the Reference Committee on motion duly made and seconded.

HOSPITAL RELATIONS

DAVID HENRY POER, M.D., *Chairman*

Only one meeting of this Committee has been held this year but fortunately its activities have been continuous. Our work has been principally in four fields, viz.:

1. Hospital Indigent Care: This bill has never been implemented by the Georgia Legislature, but the Kerr-Mills Bill is now in force. We have appointed members to serve on the Hospital Advisory Council of the Welfare and Health Department of the State Board of Health as follows: William L. Pomeroy (1963); Rafe Banks (1962), and Abe Conger (1961).
2. The Georgia League of Nurses has requested our Committee to designate a member of MAG to serve in a liaison capacity on their Advisory Board. Two names were sent to Council and their first choice refused the appointment. Council is now requested to make a second choice for this important post.
3. Para-Medical Recruitment: Career Day kits have been sent to each county medical society and the special film "I Am A Doctor" has been in constant demand. There is plenty of room for more activity in this field.
4. Georgia Hospital-Medical Council: This has become the outstanding accomplishment of our Committee, the work of which the entire Association can view with pride. Their work now is almost entirely centered in the field of improving medical care and professional standards in small hospitals. Ten inspection teams have been organized and at least as many hospitals visited. Three small hospitals have been awarded certificates and others are in the process.

On a national level they said "it couldn't be done" but our results show the contrary. Again our appreciation goes back to our President, Doctor Milford Hatcher, for the outstanding work he did in getting this Council organized and in business.

5. Doctor William Loomis Pomeroy of Waycross was named Vice-Chairman of the Committee and it is the personal recommendation of the Chairman that he now take over the helm because there is much important work to be done.

Recommendations

1. That this Committee be urged to continue its work and that Council continue to supply the necessary secretarial assistance.
2. That the Committee be requested to investigate the possibility of setting up a separate Council to bring together such related professional groups as the nurses, pharmacists, operators of nursing homes, physical therapists, and others. Particularly in the legislative field could this Council be very effective. At least one meeting each year should be held.

REFERENCE COMMITTEE RECOMMENDATION — This Committee approves and commends the report of the Hospital Relations Committee as published.

HOUSE OF DELEGATES ACTION — Adopted the report of the Hospital Relations Committee as recommended by the Reference Committee on motion duly made and seconded.

RURAL HEALTH

ALBERT L. MORRIS, M.D., *Chairman*

The Rural Health Committee of the Medical Association of Georgia has limited its scope of operations during the year to one of continuing projects begun during the previous year. It takes pride in the following accomplishments:

1. *Medical Laboratory Assistant Training Program:* This course of study is now in full operation at the North Georgia Trade and Vocational School in Clarkesville, Georgia. The first class has finished its didactic work and is now in the process of taking its six months of clinical internship. This course of training, set up according to standards put forth by the Georgia Society of Clinical Pathologists and the Georgia Chapter of the Medical Technicians ASCP, is in operation today because of the continued cooperation of these organizations. It is they who have provided the teachers, the ethics, the standards necessary to supply this needed portion to the para-medical personnel of modern medical practice. It is with great pride that the Rural Health Committee could serve as coordinator in the earlier efforts of establishing this program.

2. *Regional Conference of American Medical Association Rural Health Committee:* In October, 1960, there was held in Atlanta, Georgia, a regional conference on Rural Health under the auspices of the AMA. This conference was well attended by members from the Southeastern United States. The Rural Health Committee, along with Mr. Krueger and his staff, were able to offer assistance on a number of problems.

The Rural Health Committee suggests and makes the following recommendations for the coming year:

1. *Consolidation of Committees:* During the past three years it has become increasingly evident that the term "rural" is a misnomer. Because of better roads, more industrialization, and migration of the people of Georgia to the urban areas, the boundaries of the Committee now overlap into those of numbers of other committees. In spite of the fact that the American Medical Association continues to have a Rural Health Committee, we believe that on the State level, this Committee could be incorporated into another, larger committee. It could function more adequately as a portion of Public Health, since the problems of each committee overlap.

2. *Continued support of the Medical Laboratory Assistant Training Program:* The Committee urges the continued approval and support of the Medical Association of Georgia for the course of training now being offered at the North Georgia Trade and Vocational School in Clarkesville, Georgia. Since there is in existence already a "watch-dog" committee for this course of training, this Committee urges that the watch-dog committee serve as the liaison between the Association and the North Georgia Trade and Vocational School.

The Rural Health Committee begs to report that no money has been spent during the past year. Neither is there any project contemplated in the future which would make necessary an appropriation larger than that usually given for incidental expenses.

REFERENCE COMMITTEE RECOMMENDATION — The report of the Rural Health Committee was accepted, approved, and commended by this Committee.

HOUSE OF DELEGATES ACTION — Adopted the report of the Rural Health Committee as recommended by the Reference Committee on motion duly made and seconded.

SCIENTIFIC EXHIBIT AWARDS

TED F. LEIGH, M.D., *Chairman*

The Scientific Exhibits Committee at the present writing is receiving applications from doctors and groups over the State, for the 1961 annual meeting in Atlanta. A fairly large number of applications have already been received, ranging over a broad field of subjects. More are expected in the next two-month interval before convention time.

The Scientific Exhibits for the Atlanta meeting will be housed in the Exhibit Hall at the Biltmore Hotel, in a rectangular space between the commercial exhibits and the Lecture Hall. The layout affords ample opportunity for viewing and study to all those interested.

The scientific exhibits at the 1960 convention in Columbus offered much variety and interest. The prize winning exhibits were outstanding.

REFERENCE COMMITTEE RECOMMENDATION — This report was accepted, approved, and commended by the Committee.

HOUSE OF DELEGATES ACTION — Adopted the report of the Scientific Exhibit Awards Committee as recommended by the Reference Committee on motion duly made and seconded.

MINISTERIAL LIAISON

NEEDHAM B. BATEMAN, M.D., *Chairman*

This Committee has continued to remind the ministers and their organizations of the various denominations in Georgia of the existence and functions relative to the Ministerial Liaison Committee of the Medical Association of Georgia.

Many inquiries have been received from ministers and church officials as to assistance from members of the medical profession. These inquiries have been referred to the proper officials of the local county medical society of the area, or to the family physician of the person or family involved. To date, this has always been found to be the proper and practical thing to do, and has always resulted in a satisfactory solution to the problem at hand.

Letters have gone out to officials and members of our county medical societies reminding them of the functions of this Committee. This letter also suggested that they give consideration to the idea of setting up a similar committee on the local level to serve in a liaison capacity with the local ministers, ministerial associations, churches, and church organizations. In addition, it was suggested that the attending physician, whenever possible, maintain on an informal basis, liaison with the patients, minister and his church group for better patient care and follow-up. To date, the response to this letter and these suggestions has been excellent.

In each instance where members of the committee or other physicians have appeared by invitation before meetings of ministers or church members, they were most grateful for the remarks on the part of a member of our medical profession. Individually and collectively, they seemed to appreciate very deeply the fact that organized medicine, as well as its members, was interested in working with the ministers and their churches for the benefit of the patient as well as the people everywhere.

In closing we would like to remind you again of the aims and functions of this Committee which have always been:

- a. Create a better understanding between the ministerial and medical professions and to bring about closer cooperation between the two groups and their individual members.
- b. To place the medical profession and the individual physicians in a better light in the eyes of the clergy, the public at large, and of course, the patient and his family and friends by letting them see for themselves, the sincere desire of the Men of Medicine to serve and fulfill their duty to their profession and their fellow men.
- c. To help our physicians realize that others, especially the ministers, are dedicated to duty and to service, and that they have arduous and long hours, often under adverse circumstances, the same as the doctor; that they are often imposed upon by scheming and unscrupulous persons, and are frequently called on to work with the confused and frustrated, the inadequate, the immature, the emotionally disturbed, the physically sick, the unloved, the unwanted, and the unfortunate, the same as the doctor.
- d. To acquaint the members of the two professions with the many ways they can work with each other

to great advantage where individuals, families, committees, and peoples are concerned.

- e. To point out to ministers and their organizations how easy it is to secure doctors as speakers, members of panels, committees, etc., when the help or opinions of one trained and experienced in medicine are desired.
- f. To remind the doctor and his organization of the willingness of the minister and his organizations to work with the members and groups of the medical profession; of their understanding of us and our common problems; their readiness to join us when invited, in any worth while meeting or undertaking.
- g. To encourage physicians and physician organizations to work with the ministers, churches, civic groups, etc., for the benefit of the community and the public as a whole.
- h. To encourage each county medical society to appoint a Ministerial Liaison Committee.
- i. To tactfully suggest that our ministerial organizations on state, county, and city levels appoint Medical Liaison Committees to work along the lines of this Committee from their end of the row.
- j. To strive to keep all of this activity on the local level; that is, if a county ministerial group or church asks for a speaker or representative from the medical profession, that this request be filled through the local county ministerial committee who calls on a local physician to fulfill this assignment. A local physician can do a better job in such cases and, of course, will be much more appreciated than some one from afar just there for the occasion.
- k. To accept our duties as they come, giving of our time, strength, ability, and resources as they require.
- l. To be careful not to trespass on the territory of any other Medical Association of Georgia group or committee, and also being sure not to accept any duty that could more properly be handled by the officials, or other committee of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION — This report was accepted, approved, and commended by the Committee.

HOUSE OF DELEGATES ACTION — Adopted the report of the Ministerial Liaison Committee as recommended by the Reference Committee on motion duly made and seconded.

REPORT OF THE JOURNAL

EDGAR WOODY, JR., M.D., *Editor*

The 1960-61 Report of the *Journal of the Medical Association of Georgia* is submitted herewith:

Personnel

We are very pleased to announce that there have been no changes in the full-time personnel employed by the *Journal* in the past year. Mrs. Anne W. Kirkland, who became Managing Editor more than two years ago, is continuing to function in that capacity.

There have been no additions to our staff of contributing editors during the past year. These editors have continued to be effective in their contributions of editorials, solicitation of desirable scientific papers for

publication, and contributions to our feature page "Current Clinical Concepts."

Conferences

In October of 1960, the Editor and Managing Editor attended a conference in Lexington, Kentucky, sponsored this year by the Kentucky State Medical Association. These meetings are held every other year and are sponsored by different associations each year. The growth in attendance of these meetings proves their usefulness to all those attending.

Content

Although there has been a noticeable decrease in advertising from national sources during the past 12 months, the *Journal* has continued to carry the same amount of editorial copy. This decrease in advertising hit not only the *JMAG*, but every other medical journal.

The *Journal* continues to print an average of six scientific articles per month, most of which are presented at the Annual Session. We have been fortunate during the past year to receive a considerable number of excellent scientific papers which have been solicited by our contributing editors.

The special feature pages, including the Heart Page, the President's Letter, the Cancer Page, Current Clinical Concepts, the Mental Health Page, the Legal Page, and Physician's Bookshelf, have been continued.

A feature in the form of an insert page, Top of the News, has continued to attract good readership by virtue of the freshness and timeliness of the news it presents and its easily readable and concise style.

One of our oldest features, Abstracts by Georgia Authors, continues active and popular.

In the September and October 1960 issues, a "get-out-and-vote" campaign was launched. In these issues, editorials were written and a poster for your office, announcing that certain hours during election day your office would be closed to allow you and your personnel to vote, was included. Reprints of the editorials and poster, along with a letter of explanation, were sent to all presidents of the state medical associations and editors of their journals. These were received very enthusiastically and over 25 states replied that they too would endorse such a campaign.

The *Journal* has increased its use of supplements to the *Journal*. In this way special attention is called to important activities currently being promoted by the MAG or other noteworthy organizations.

Format and Typography

During the past year increasing use has been made of the services of Mr. John S. McKenzie of the Higgins-McArthur Printing Company in the design of our *Journal* covers and general typography of the *Journal*. On several occasions the photographic services of Mr. Joe Jackson of Emory University have been helpful in the illustration of covers and feature material. Also Miss Kathleen Mackay, Department of Medical Illustration, Emory University, has been very helpful with illustrations for the cover.

All type sizes have continued the same, with a few alterations each month for variety.

The only major change in the *Journal* has been the redesign of the contents page. We feel that this change

was necessary for its increased attractiveness and readability.

Mr. Milton Krueger, Mr. John Kiser, and Mr. Jim Moffett, MAG's new Assistant Executive Secretary, were very helpful during the year in supplying news of the Association and its activities for the columns of the *Journal*.

From the editor's point of view, 1960-61 has been a very satisfactory year. It is hoped that our readers feel that progress has been made.

REFERENCE COMMITTEE RECOMMENDATION — This report was accepted, approved, and commended by the Committee.

HOUSE OF DELEGATES ACTION — Adopted the report of the *Journal of the Medical Association of Georgia* as recommended by the Reference Committee on motion duly made and seconded.

It was moved by Chairman of Reference Committee No. 5, John T. Godwin, Atlanta, and duly seconded that the report of Reference Committee No. 5 be approved as a whole and it was so ordered.

Unfinished Business

Speaker Walker called for unfinished business and recognized J. W. Chambers, LaGrange. Dr. Chambers presented a commendation to the outgoing Speaker of the House of Delegates, Dr. Thomas W. Goodwin, for his nine years of dedicated and devoted service as Speaker of the House. A rising vote of commendation was given Dr. Goodwin at this time.

Speaker Walker then introduced the next order of unfinished business, declaring that the office of Vice Speaker of the House of Delegates was at this time vacant and nominations would then be in order from the floor to fill this elected office for the unexpired term of one year. Dr. Walker stated that as Vice Speaker of the House, he had assumed the position of Speaker of the House upon the resignation of Dr. Goodwin and that the office of Vice Speaker must now be filled. He requested nominations from the floor from the delegates present and voting.

Dr. Joseph Mercer, Brunswick, was nominated by T. A. Peterson, of Savannah, and seconded by Lester Rumble, Atlanta.

Speaker Walker called for additional nominations and there being none, the nominations were declared closed on motion duly made and seconded.

Speaker Walker then ruled that Joseph Mercer was elected without opposition to the office of Vice Speaker to fill the unexpired term of one year for that office.

Speaker Walker called for new business and there being none, the Second Session of the House of Delegates of the Medical Association of Georgia held in conjunction with the Association's 107th Annual Session was declared adjourned at 9:45 A.M.

GENERAL BUSINESS SESSION

107th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

SUNDAY, MAY 7, 1961

THE FIRST GENERAL BUSINESS SESSION of the 107th Annual Session of the Medical Association of Georgia was called to order by President Milford B. Hatcher, Macon, at 2:10 P.M. in the Main Meeting Hall of the Atlanta Biltmore Hotel, Atlanta, Georgia, on May 7, 1961.

President Hatcher welcomed the membership and stated that the first order of business would be the nominations of Officers and Councilors. President Hatcher clarified voting rules and voting hours which were to begin immediately following the nominations at this session from 2:30 P.M. to 5:00 P.M.; then again to open at 9:00 A.M. to 5:00 P.M. on Monday, May 8 and again to open at 9:00 A.M. to 5:00 P.M. on Tuesday, May 9, closing the ballot box at that time.

President Hatcher then called for nominations from the floor for Association Officers and the nominations were made as follows:

Nominations

President-Elect—Thomas Goodwin, Augusta; nominated by David R. Thomas, Augusta; seconded by W. P. Rhyne, Albany; George Dillinger, Thomasville; Ruskin King, Savannah; A. W. Simpson, Jr., Washington; J. G. McDaniel, Atlanta, and Henry Tift, Macon.

There being no other nominations for the office of President-Elect, President Hatcher instructed the Secretary to cast a unanimous ballot for Thomas Goodwin as President-Elect for the Medical Association of Georgia.

First Vice President—Linton H. Bishop, Atlanta; nominated by Mark Dougherty, Atlanta; seconded by Hoke Wammock, Augusta; Henry Tift, Macon, and J. Frank Walker, Atlanta.

There being no further nominations, President Hatcher instructed the Secretary to cast a unanimous ballot for Linton H. Bishop, Atlanta, as First Vice President of the Association.

Second Vice President—Lee Battle, Rome; nominated by William Harbin, Rome; seconded by John Elliott, Savannah.

There being no other nominations, President Hatcher instructed the Secretary to cast a unanimous ballot for Lee Battle, Rome, as Second Vice President of the Association.

AMA Delegate (term beginning January 1, 1962) — J. W. Chambers, LaGrange; nominated by Enoch Callaway, LaGrange; seconded by J. G. McDaniel, Atlanta; T. A. Peterson, Savannah, and Luther Wolff, Columbus.

There being no other nominations, President Hatcher instructed the Secretary to cast a unanimous ballot for the election of J. W. Chambers, LaGrange, as AMA Delegate.

AMA Alternate Delegate (term beginning January 1, 1962)—George Dillinger, Thomasville; nominated by W. P. Rhyne, Albany; seconded by Braswell Collins, Macon.

There being no other nominations, President Hatcher instructed the Secretary to cast a unanimous ballot to elect George Dillinger, Thomasville, as AMA Alternate Delegate.

President Hatcher then referred to Chapter V, Section 2 of the MAG Constitution and Bylaws as follows: "Nominations for Councilors and Vice Councilors shall be made by each district society at its annual meeting and forwarded by its Secretary to the Secretary of the Association not later than 15 days before the Annual Session. If no nomination is presented by a district society in this manner, nominations shall be made from the floor. Nominations from those county medical societies having 100 or more active members which are entitled to elect one Councilor and one Vice Councilor directly representing that society shall be forwarded in like manner as a district society for election by ballot by the members of the Association during the Annual Session."

President Hatcher then read the nominations received from the First, Second, Third, Fourth, Fifth, and Sixth District Medical Societies and the nominations received from Georgia Medical Society, Richmond County Medical Society, Muscogee County Medical Society, Bibb County Medical Society, and Fulton County Medical Society. These nominations, having been received 15 days prior to the Annual Session, were read as follows:

First District Councilor (1964)—Charles Bohler, Brooklet.

First District Vice Councilor (1964)—William Simmons, Sylvania.

Second District Councilor (1964)—George Dillinger, Thomasville.

Second District Vice Councilor (1964)—W. Frank McKemie, Albany.

Third District Councilor (1964)—Frank Wilson, Leslie.

Third District Vice Councilor (1964)—Robert Martin, Cuthbert.

Fourth District Councilor (1964)—Virgil Williams, Griffin.

Fourth District Vice Councilor (1964)—C. T. Cowart, LaGrange.

**Fifth District Councilor* (1962)—Floyd Sanders, Decatur.

**Fifth District Vice Councilor* (1962)—Lawrence Matthews, Decatur.

**Sixth District Councilor* (1962)—William Rawlings, Sandersville.

**Sixth District Vice Councilor* (1962)—John Bell, Dublin.

Georgia Medical Society Councilor (1964)—Walter Brown, Savannah.

Georgia Medical Society Vice Councilor (1964)—T. A. Peterson, Savannah.

Richmond County Medical Society Councilor (1963)—H. D. Pinson, Augusta.

Richmond County Medical Society Vice Councilor (1963)—J. L. Mulherin, Augusta.

Muscogee County Medical Society Councilor (1962)—W. P. Jordan, Columbus.

Muscogee County Medical Society Vice Councilor (1962)—Luther Wolff, Columbus.

Bibb County Medical Society Councilor (1963)—George Alexander, Forsyth.

Bibb County Medical Society Vice Councilor (1963)—W. H. M. Weaver, Macon.

Fulton County Medical Society Councilor (1963)—J. G. McDaniel, Atlanta.

Fulton County Medical Society Vice Councilor (1963)—Charles S. Jones, Atlanta.

President Hatcher then asked the Secretary to cast a unanimous ballot for the above named District and County Medical Society Councilors and Vice Councilors. At this time President Hatcher stated that there were no contested offices and that the Tellers Committee need not conduct general balloting for Association offices.

GP of the Year Award

President Hatcher stated that according to the rules for the presentation of the "General Practi-

**To Fill Unexpired Term Due to Resignation.*

tioner of the Year" award, the MAG Council had received two nominations for this honor. These nominations presented are as follows:

Harry Bell Bradford, Cartersville, nominated by the Bartow County Medical Society.

J. W. Palmer, Ailey, nominated by the Southeast Georgia Medical Society.

President Hatcher then called for nominations from the floor and there being none, he informed the general membership that the House of Delegates would vote on these two candidates for this high honor at the First Session of the House of Delegates.

Hardman Award

President Hatcher stated that the MAG Council had received two nominations for the Hardman Award and he presented these nominations as follows:

Rudolph A. Bartholomew, Atlanta, nominated by the Fulton County Medical Society.

Robert Connor Pendergrass, Americus, nominated by the Southwest Georgia Medical Society.

There being no further nominations, President Hatcher informed the general membership that these two nominations would be considered and voted upon by the House of Delegates at the First Session of the House.

There being no further business, the First General Business Session of the 107th Annual Session of the Medical Association of Georgia was recessed at 2:35 P.M.

GENERAL BUSINESS SESSION (Second Session)

107th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

MONDAY, MAY 8, 1961

THE SECOND GENERAL BUSINESS SESSION of the 107th Annual Session of the Medical Association of Georgia was called to order by President Milford B. Hatcher, Macon, at 12:20 P.M. in the Main Meeting Hall of the Atlanta Biltmore Hotel, Atlanta, Georgia, on Monday, May 8, 1961.

The Invocation was given by the Rev. W. Candler

Budd, D.D., Pastor, Northside Methodist Church, Atlanta, Georgia.

A word of welcome was delivered by J. G. McDaniel, President of the Fulton County Medical Society, hosts for this Session. Dr. McDaniel welcomed the members of the Medical Association of Georgia to Atlanta for the 1961 Annual Session.

The Honorable William B. Hartsfield, Mayor of Atlanta, Georgia, welcomed the MAG members, their wives, and guests to Atlanta on the occasion of the 107th Annual Session of the Association.

President Hatcher then turned the gavel over to First Vice President Simone Brocato of Columbus, as Presiding Officer. Dr. Brocato then introduced President Milford B. Hatcher who addressed the membership on the subject "Report of the Presidential Year 1960-61."

On completion of the President's speech, Dr.

Hatcher again assumed the duties of presiding officer.

President Hatcher then introduced President-Elect Fred H. Simonton, Chickamauga, who addressed the Association membership on the subject "Our Association Future."

Upon completion of the address by President-Elect Fred Simonton, Dr. Hatcher recessed the Second General Business Session of the 107th Annual Session of the Medical Association of Georgia at 1:25 P.M.

GENERAL BUSINESS SESSION (Third Session)

107th ANNUAL SESSION OF THE MEDICAL ASSOCIATION OF GEORGIA

WEDNESDAY, MAY 10, 1961

THE THIRD GENERAL BUSINESS SESSION of the 107th Annual Session of the Medical Association of Georgia was called to order by President Milford B. Hatcher, Macon, at 11:05 A.M. in the Main Meeting Hall of the Atlanta Biltmore Hotel, Atlanta, Georgia on Wednesday, May 10, 1961.

President Hatcher announced that a compilation of the official attendance at the 107th Annual Session of the Medical Association of Georgia was as follows: MAG Members — 876; Other M.D.'s Attending—144; Guests—268, and Exhibitors Registered—148, making a grand total of 1,427 registrants.

Fifty-Year Certificates

President Hatcher called on Luther Wolff, Columbus, Immediate Past President, who presented Fifty-Year Certificates and Pins to physician members who have practiced medicine for 50 years or more. These presentations were made to the following physicians: Malcolm W. Anderson, Social Circle; Frank Bird, Lake Park; Montague L. Boyd, Atlanta; Thomas H. Brabson, Cornelia; Allen H. Bunce, Atlanta; William L. Cousins, Atlanta; Leo P. Daly, Atlanta; Bruce Jackson, Newnan (Dec.); Andrew J. Jones, Jacksonville; Spencer A. Kirkland, Atlanta (Dec.); George H. Lang, Savannah; Samuel J. Lewis, Augusta; D. R. Longino, Atlanta; James C. McDougall, Atlanta; Rubin S. O'Neal, LaGrange;

James A. Redfearn, Albany; Joseph R. Robertson, Augusta; Ernest B. Saye, Milledgeville; Thomas H. Smith, Valdosta, and Claude V. Vansant, Sr., Douglasville.

Scientific Exhibit Awards

President Hatcher called on Ted F. Leigh, Atlanta, Chairman of the Association Scientific Exhibit Awards Committee, who made the following presentations:

First Place Award—"Advances in Surgical Treatment of Hearing Loss"—

Claude L. Pennington, M.D., Macon.

Second Place Award—"A Potent Propulsion Procedure for Aorto-Arteriography"—

Russell Wigh, M.D.; William F. Lindsey, M.D.; Jack Morgan, M.D., and Winfred H. Pool, M.D., Augusta.

Third Place Award—"The Poponicoloou Smeor, A Screening Test for Cancer"—

D. F. Mullins, Jr., M.D.; C. I. Bryans, Jr., M.D.; F. P. Zuspan, M.D., and W. L. Sutherland, M.D., Augusta.

Honorable Mention—"Various Aspects of an Interposed Non-Metallic Filter in Diagnostic Radiography"—

John J. Douglas, M.D., LaGrange.

Honorable Mention—"Management of Hand Disabilities"—

C. Martin Rhode, M.D., Augusta.

Honorable Mention—"Improved Method of Interorificial Gommo Roy Therapy"—

Enoch Callaway, M.D., LaGrange.

GP of the Year Award

President Hatcher called on T. A. Peterson to present the GP of the Year Award. Dr. Peterson

presented the 1961 "General Practitioner of the Year Award" to J. W. Palmer, Ailey.

Certificates of Appreciation

President Hatcher recognized John T. Mauldin, Atlanta, Association Secretary, who presented the MAG Certificates of Appreciation. Dr. Mauldin presented the following Certificates of Appreciation in behalf of the Association: Samuel U. Braly, Dallas, awarded for Dedicated Civic Leadership; Charles T. Brown, Guyton, awarded for service as MAG Councilor, First District, 1957-61; Walter G. Elliott, Cuthbert, awarded for service as Third District Councilor, 1947-1961; Milford B. Hatcher, Macon, awarded for services as MAG President, 1960-61; John P. Heard, Decatur, awarded for service as Chairman of MAG's Committee on Public Service; J. G. McDaniel, Atlanta, awarded for service as Chairman of the MAG Council, 1959-61; Christopher J. McLoughlin, Atlanta, awarded for service as MAG Secretary, 1957-60; J. Z. McDaniel, Albany, awarded for service as MAG Vice Councilor from the Second District, 1955-61; Louis M. Orr, Orlando, Florida, awarded for service to organized medicine while serving as AMA President, 1959-60; Jack H. Powell, Jr., Newnan, awarded for service as Fourth District MAG Vice Councilor from 1959-61; Mrs. W. P. Rhyne, Albany, awarded for service as President of the Auxiliary to the Medical Association of Georgia, 1960-1961; Thomas W. Goodwin, Augusta, awarded for service as Speaker of the MAG House of Delegates, 1953-61; Peter Hydrick, College Park, awarded for service as Chairman of MAG Annual Session Commercial Exhibits Committee, 1955-60; Ted F. Leigh, Atlanta, awarded for service as Chairman of the MAG Annual Session Scientific Exhibits Committee, 1955-61, and Henry Tift, Macon, awarded for service as Chairman of the MAG Annual Session Committee, 1959-61.

Hardman Cup Award

President Hatcher called on President-Elect Fred Simonton, Chickamauga, to present the Hardman Award Cup. Dr. Simonton presented the Hardman Award Certificate and Cup to Robert Conner Pendergrass of Americus.

President's Key

Association Secretary John T. Mauldin, in behalf of the officers and the members of the Medical Association of Georgia, presented President Hatcher with a President's Key and a bound copy of the *Journal of the Medical Association of Georgia* as published during the term of office of President Hatcher. President Hatcher made an acceptance speech and thanked the Association for the privilege

of having served as its president during the year 1960-61.

Election Results

President Hatcher stated that as none of the elected offices of the Association were contested, and that as he had instructed the Secretary of the Association to cast a unanimous ballot for these elective offices at the First General Business Session held May 7, 1961, that there would be no need for a report from the Tellers Committee.

Site of 1962-1963 Annual Session

President Hatcher announced that the site for the 1962 Annual Session had been previously set for Savannah, Georgia, on the invitation of the Georgia Medical Society. He then called for invitations for the site of the 1963 Annual Session. Jule Neal of Macon rendered an invitation to the Association to meet in Macon in 1963. Also, at this time C. A. Wilson, Jr., of Brunswick, invited the Association to hold their 1963 meeting at Jekyll Island. President Hatcher then said these two invitations would be referred to the Council, which is duly authorized according to the Constitution and Bylaws to set the time and place of the MAG Annual Sessions.

Installation of Officers

The next order of business was the installation of the 1961-62 officers by President Hatcher as follows:

- President*—Fred H. Simonton, Chickamauga (1962)
- President-Elect*—Thomas W. Goodwin, Augusta (1962)
- Immediate Past President*—Milford B. Hatcher, Macon (1962)
- First Vice President*—Linton Bishop, Atlanta (1962)
- Second Vice President*—Lee Battle, Rome (1962)
- Speaker of the House*—J. Frank Walker, Atlanta (1962)
- Vice Speaker of the House*—Joseph Mercer, Brunswick (1962)
- AMA Delegate* (term beginning January 1, 1962)—J. W. Chambers, LaGrange (December 30, 1963)
- AMA Alternate Delegate* (term beginning January 1, 1962) George Dillinger, Thomasville (December 30, 1963)
- First District Councilor*—Charles Bohler, Brooklet (1964)
- First District Vice Councilor*—William Simmons, Sylvania (1964)
- Second District Councilor*—George Dillinger, Thomasville (1964)
- Second District Vice Councilor*—W. Frank McKemie, Albany (1964)
- Third District Councilor*—Frank Wilson, Leslie (1964)
- Third District Vice Councilor*—Robert Martin, Cuthbert (1964)
- Fourth District Councilor*—Virgil Williams, Griffin (1964)
- Fourth District Vice Councilor*—C. T. Cowart, LaGrange (1964)
- Fifth District Councilor*—Floyd Sanders, Decatur (1962)
- Fifth District Vice Councilor*—Lawrence Matthews, Decatur (1962)
- Sixth District Councilor*—William Rawlings, Sandersville (1962)
- Sixth District Vice Councilor*—John Bell, Dublin (1962)

Georgia Medical Society Councilor—Walter Brown, Savannah (1964)
Georgia Medical Society Vice Councilor—T. A. Peterson, Savannah (1964)
Richmond County Medical Society Councilor—H. D. Pinson, Augusta (1963)
Richmond County Medical Society Vice Councilor—J. L. Mulherin, Augusta (1963)
Muscogee County Medical Society Councilor—W. P. Jordan, Columbus (1962)
Muscogee County Medical Society Vice Councilor—Luther Wolff, Columbus (1962)
Bibb County Medical Society Councilor—George Alexander, Forsyth (1963)
Bibb County Medical Society Vice Councilor—W. H. M. Weaver, Macon (1963)

Fulton County Medical Society Councilor—J. G. McDaniel, Atlanta (1963)
Fulton County Medical Society Vice Councilor—Charles S. Jones (1963)

Immediate Past President Milford B. Hatcher then turned the gavel over to President Fred H. Simonton.

There being no further business, President Simonton adjourned the 107th Annual Session of the Medical Association of Georgia held at the Atlanta Biltmore Hotel, Atlanta, Georgia, May 7-10, 1961, at 12:00 noon.

Remember These Dates for Your Calendar

MAY 6-9, 1962

These are the dates for the

ANNUAL SESSION

of the

**MEDICAL ASSOCIATION
OF GEORGIA**

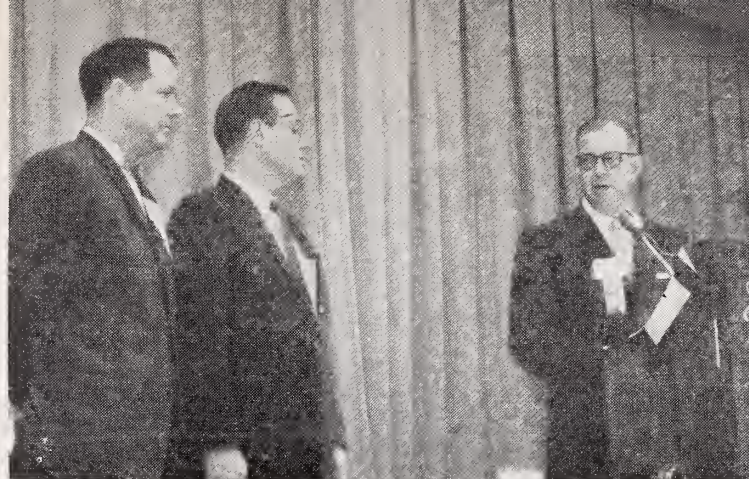


to be held in

SAVANNAH, GEORGIA



Thomas W. Goodwin, President-Elect



Linton Bishop, First Vice Pres., J. Frank Walker, Speaker of the House take Oath of Office.



Milford B. Hatcher turns gavel over to Fred Simonton.

ANNUAL SESSION 1961

J. W. Palmer receives GP Award



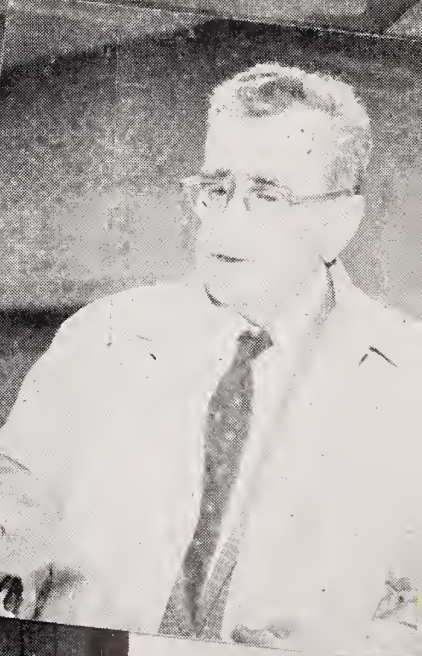
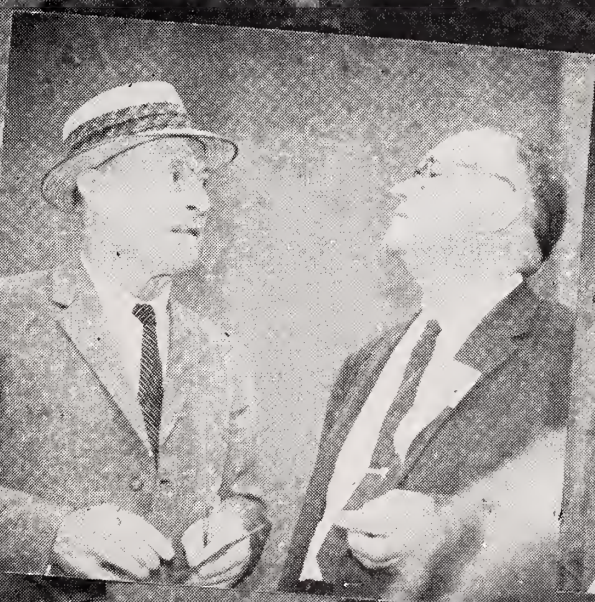
R. C. Pendergrass receives Hardman Award

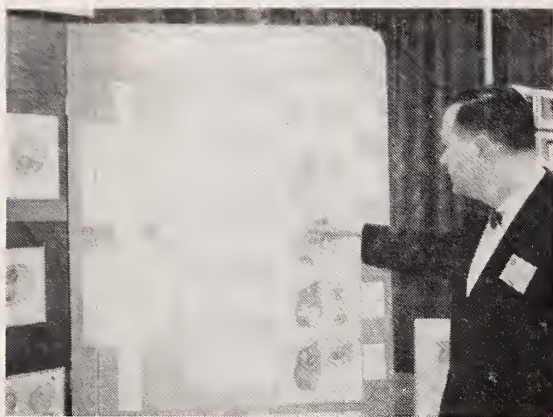




Glimpses at Annual Session

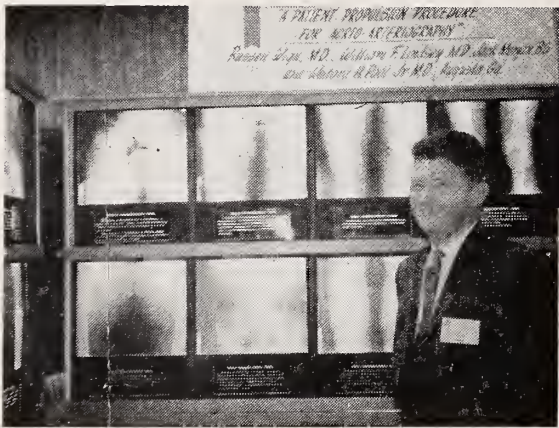






Claude L. Pennington First Place Scientific Exhibit Award.

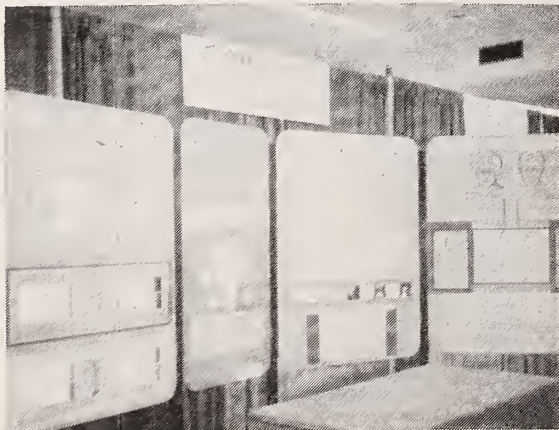
Milford B. Hatcher Immediate Past President



Russell Wigh, William F. Lindsey, Jack Morgan and Winford H. Pool, Jr., Second Place Scientific Exhibit Award.



Mrs. W. P. Rhyne, Immediate Past President Woman's Auxiliary to MAG.



D. F. Mullins, Jr., C. I. Bryans, Jr., F. P. Zuspan, W. L. Southerland Third Place Scientific Exhibit Award.

1961 CALENDAR OF MEETINGS

State

- July 10-28—Emory University's School of Nursing, short-term, intensive courses, Emory University, Atlanta.
- Aug. 11-12—Seminar in Medical Aspects of Sports, Macon, Ga.
- Sept. 8-9—Thirteenth Annual Meeting, Georgia Heart Association, Jekyll Island.
- Oct. 12-14—Georgia Academy of General Practice, Annual Session, Jekyll Island.
- May 6-9—Annual Session, Medical Association of Georgia.**

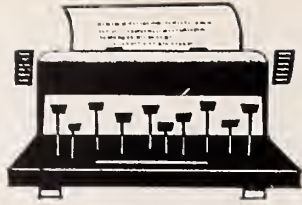
Regional

- Aug. 17-19—Annual Obstetric Pediatric Postgraduate Seminar, Colonial Inn, St. Petersburg Beach, Fla. (12 pts. Cat. I)
- Sept. 19-21—Kentucky State Medical Association, Brown Hotel, Louisville, Kentucky.
- Sept. 25-26—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tennessee.
- Oct. 21—Southeastern Allergy Association, Thomas Jefferson Inn, Charlottesville, Va.
- Nov. 6-9—Southern Medical Association, Municipal Auditorium, Dallas, Texas.
- Dec. 5-7—Southern Surgical Association, Hot Springs, Vir., a.a.
- Mar. 2—Southeastern Surgical Congress, Louisville, Ky.
- Mar. 26-28—American College of Surgeons, Sectional Meeting, Hotel Peabody, Memphis, Tenn.
- April 8-11—Tennessee State Medical Association, Peabody Hotel, Memphis, Tenn.
- April 26-28—Alabama, Medical Association of the State of, Tutwiler Hotel, Birmingham, Ala.
- May 12-15—Texas Medical Association, Austin, Tex.

National

- June 26-30—American Medical Association, Annual Meeting, New York, New York.**
- July 2-7—American Physical Therapy Association, Palmer House, Chicago, Illinois.
- July 10-13—University of Colorado School of Medicine, Postgraduate Course, Estes Park, Colorado.
- July 24-28—American College of Chest Physicians, Postgraduate Course, Brown Hotel, Denver, Colorado.
- July 27-29—Dermatology for the General Practitioner, post graduate course, Estes Park, Colo.
- Aug. 7-12—Hepatic Pathology, post graduate course in Pediatrics, Estes Park, Colo.
- Sept. 8-Nov. 10—New York University Postgraduate Medical School, Occupational Medicine, New York University Medical Center, New York, New York.
- Sept. 23-30—University of Illinois College of Medicine, Annual Otolaryngologic Assembly, Chicago, Ill.
- Sept. 25-28—American Hospital Association, Atlantic City, New Jersey.
- Sept. 25-29—American College of Chest Physicians, Postgraduate Course, Warwick Hotel, Philadelphia, Pennsylvania.

- Sept. 26-29—American Roentgen Ray Society, Deauville Hotel, Miami Beach, Florida.
- Sept. 28-30—American Association for the Surgery of Trauma, Drake Hotel, Chicago, Illinois.
- Sept. 30 - Oct. 3—College of American Pathologists, Seattle, Washington.
- Sept. 30-Oct. 8—American Society of Clinical Pathologists, Olympic Hotel, Seattle, Washington.
- Oct. 1-7—College of American Pathologists, Olympic Hotel, Seattle, Washington.
- Oct. 2-5—American Academy of Pediatrics, Palmer House, Chicago, Illinois.
- Oct. 2-6—American College of Surgeons, Conrad Hilton Hotel, Chicago, Illinois.
- Oct. 3-4—Congress on Occupational Health, Brown Palace Hotel, Denver, Colo.
- Oct. 8-13—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Illinois.
- Oct. 12-13—Congress of Neurological Surgeons, Summit Hotel, New York City.
- Oct. 15-20—Fourth International Congress of Allergology, the Hotel Commodore, New York, New York.
- Oct. 20-24—34th Annual Meeting, American Heart Association, Miami Beach, Florida.
- Oct. 22-25—American College of Gastroenterology, Hotel Cleveland, Cleveland, Ohio.
- Oct. 22-27—American Society of Anesthesiologists, Inc., Statler Hilton, Los Angeles, California.
- Oct. 23-24—American Cancer Society, Biltmore Hotel, New York City.
- Oct. 23-27—American College of Chest Physicians, Postgraduate Course, Sheraton-Chicago Hotel, Chicago, Illinois.
- Oct. 25-29—American Society of Clinical Hypnosis, St. Louis, Missouri.
- Nov. 2-12—Second Postgraduate Medical Seminar Cruise through the Caribbean. (College of Medicine, University of Florida)
- Nov. 4-5—American Medical Association Conference on Disaster Medical Care, Chicago.
- Nov. 9-11—American Academy for Cerebral Palsy, Chase & Park Plaza Hotels, St. Louis.
- Nov. 13-17—American College of Chest Physicians, Postgraduate Course, Park Sheraton Hotel, New York, New York.
- Nov. 13-17—American Public Health Association, Cobo Hall, Detroit, Mich.
- Nov. 16-18—American Psychiatric Association, Hotel Schroeder, Milwaukee, Wis.
- Nov. 25-Dec. 1—Radiological Society of North America, Inc., Palmer House, Chicago.
- Nov. 27-30—American Medical Association, Clinical Meeting, Denver, Colorado.**
- Dec. 4-8—American College of Chest Physicians, Postgraduate Course, Statler-Hilton Hotel, Los Angeles, California.
- Feb. 5-7—American Academy of Allergy, Denver-Hilton Hotel, Denver, Colorado.
- Feb. 7-10—American College of Radiology, Roosevelt Hotel, New York, New York.
- April 2-5—American College of Obstetricians and Gynecologists, Palmer House, Chicago, Illinois.



editorials

MAG Committee Reorganization

THE MOST COMPLICATED task that one can perform is to keep something simple. As we progress and expand, which we should and will continue to do, it is difficult to retain our equilibrium.

The Medical Association of Georgia like industry or any other progressive organization at times has to "take stock" of itself and see if it is progressing in the correct manner and if and how things can be improved. Quite frequently some small administrative change can aid immensely in efficiency and results.

During the past year it was felt that your Association should "take such stock" and re-evaluate and reorganize its set-up from an administrative standpoint in order to keep all phases properly correlated with one another and with the officers and Headquarters staff and Council. When the House of Delegates is not in session, your Council acts in its place, and when Council is not in session the Executive Committee which meets monthly acts for the Council. At other times your President is the responsible officer. Thus, you can see how it is necessary that these components of your Association need to know the developments and proceedings of activities at all times, what liaison is going on, what committees are meeting, and what action they are taking.

Study of the organization revealed that innumerable committees were performing the identical function, investigating and carrying out the same functions, quite frequently without cognizance of what the other was doing. There was not any direct report back to your officers, Council, or Executive Committee. It was impossible for your officers to

properly correlate the activities of the Association as there was not sufficient centralization of reports.

With this in mind, your Reorganization Committee under the Chairmanship of Dr. George Dillinger, along with members of the Executive Committee and Council, worked out a system by which we would have Boards, and these Boards are responsible to Council and Executive Committee which in turn are responsible to the House of Delegates. The Constitution and Bylaws Committee, under Dr. Tom Goodwin of Augusta with the advice of our legal advisors, wrote the changes necessary for implementation of this reorganization, and your recent House of Delegates enacted authority to your officers and staff to proceed with this reorganization.

Basically, the Executive Committee will be able to handle routine administrative functions; your Council will be able to receive reports of committees, liaison representatives and guide the policy of the organization until the House of Delegates are convened. They are then to report to the House of Delegates, the governing body of the Medical Association of Georgia.

With this set-up the committees and subcommittees will report back to their Boards, with a member of Council on each Board. The Boards will in turn report to Council, and this will enable Council to know better the activities of the Society.

It is felt that these changes will aid the Medical Association of Georgia to function more efficiently and effectively—and very likely, we hope, with less work and strain for all concerned.

*Milford B. Hatcher, M.D.
Immediate Past-President*

Towards Improved Results in the Management of Diverticulitis

DIVERTICULITIS OF THE COLON, and more particularly the sigmoid colon, is a disease seen with increasing frequency in patients past 50 years of age. With the increasing number of older people in our general population this disease and its adequate treatment has assumed an understandably more important role in our surgical thinking. Medical philosophy in general has assumed a more aggressive attitude in the management of diseases in the aging. No longer can we be satisfied with prolongation of life. Prolonged life with satisfactory health is our present goal.

Diverticulitis as a serious and unpredictable disease has long been a recognized entity. Until the last decade, however, surgical intervention was not seriously considered until added complications had occurred. The surgeon did not see these cases until resistant abscesses, fistulae or major hemorrhage was the presenting problem. The usual procedure under these circumstances was to perform a transverse colostomy. Some three to six months later a colon resection would be done. It was frequently necessary to do an ancillary small bowel or bladder resection because of fistulae. If the patient survived this procedure the transverse colostomy was closed in six to eight weeks. All told eight to 12 months of disability was necessary to carry out the necessary surgical corrections. Not only was the morbidity most unsatisfactory, but the overall surgical mortality in the three procedures approached 15 per cent.

Because of the unsatisfactory results outlined above a new approach is being adopted in the management of diverticulitis. Essentially the guiding principle now is to attack the disease surgically before complications have developed. An elective colon resection with end to end anastomosis can be done in one stage with a mortality of three per cent or less, and a morbidity of weeks rather than months.

Most patients with diverticulitis have a number of acute episodes before an abscess or fistula occurs. Our responsibility is to evaluate these cases, to identify those having repeated acute episodes or smouldering disease, and to advise colon resection before other complications occur. This cannot always be accomplished, but with this approach a number of older people can be spared the ordeal of multiple procedures with prolonged morbidity and high mortality risk. Dr. Frederick Collier made a statement regarding gallstones which applies equally well to diverticulitis. It goes something like this: "The neglected elective surgery of middle life becomes the tragic surgical emergency in the aged."

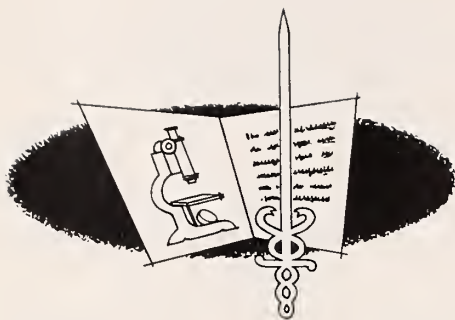
In our efforts to maintain health as well as life for a longer period of time we become increasingly aware of the need for preventive surgery. The 60 year old patient can safely undergo elective surgery, but can ill afford the hurried emergency. The good results being obtained in the early surgical attack on diverticulitis seems to justify its extended use in the future.

FIFTY YEARS OF MEDICAL DEVOTION

THE MEDICAL ASSOCIATION of Georgia was proud to award certificates to the following members for practicing medicine in Georgia for 50 years: Malcolm W. Anderson, Social Circle; Frank Bird, Lake Park; Thomas H. Brabson, Cornelia; Andrew J. Jones, Jacksonville; George H. Lang, Savannah; Samuel J. Lewis, Augusta; Ruben S. O'Neal, LaGrange; James A. Red-

fearn, Albany; Joseph R. Robertson, Augusta; Ernest B. Saye, Milledgeville; Thomas H. Smith, Valdosta; Claude V. Vansant, Sr., Douglasville; Montague L. Boyd, Allen H. Bunce, William L. Cousins, Leo P. Daly, Dick R. Longino, James C. McDougall, all of Atlanta.

Spencer A. Kirkland of Atlanta and Bruce Jackson of Newnan died during their 50th year of practice.



cancer page

PAPANICOLAOU SMEAR TECHNIQUE

A. H. Letton, M.D., *Atlanta*

IT IS NOW ABOUT 10 years since the Papanicolaou smear technique began to be used by an appreciable number of physicians, and about five years since it began to be applied to as many as two per cent of American women in one year.

In February of this year, the Gallup Organization questioned a representative sample of American women about their familiarity with various examinations which are of value in the detection and diagnosis of cancer, including the vaginal cytology examination. Following are some of the facts revealed by the poll:

Out of every 10 adult women in the United States, four report that they have heard of the vaginal cytology examination—"Pap" smear—either by name or by its description. Of the remaining six who have heard of it, three have had the examination at least once, and the other three have never had it. More than half of those who have had the procedure had it long enough ago so that they are now overdue for another since it should be on a once-a-year basis.

The American Cancer Society views these facts with great concern. An estimated 32,000 new cases of uterine cancer will occur this year, and 14,000 women will die from uterine cancer during the next 12 months if the present rate continues. Yet, this painless, five-minute examination can detect uterine cancer when it is almost 100 per cent curable.

In view of these facts, the American Cancer Society is planning to intensify its efforts to reach women with information about this examination and urge them to request it from their family physicians. The Society plans increased use of its film "Time and

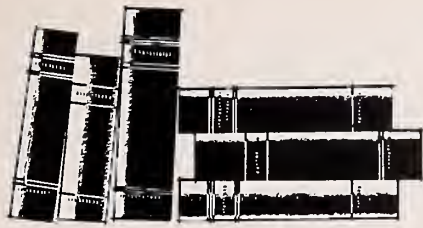
Two Women" which demonstrates the "Pap" smear examination and points up its importance, and a wider distribution of literature explaining this examination.

A major effort to receive the Society's attention during the next year will be a project called "Conquer Uterine Cancer," to be conducted in conjunction with the General Federation of Women's Clubs. This effort is aimed at getting members of the 17,000 women's clubs throughout the nation to have a health checkup including a "Pap" smear examination during the next 12 months. It appears that response to this project in Georgia is going to be very gratifying.

In 1959, "cancer of the uterus" accounted for 495 deaths in Georgia. It is the second leading cause of cancer deaths in Georgia, surpassed only by lung cancer which claimed 554 Georgians in 1959. Despite the potentially very high curability of "uterine cancer" it remains as the leading cause of cancer deaths in women.

The American Cancer Society urges you to inform your patients of the importance of having "Pap" smears made regularly as a safeguard against needless cancer deaths, and to include the examination as part of all health checkups for your adult female patients.

It is hard enough to face the fact that we are losing thousands of cancer patients because research has not yet given us the tools to save them. It is even harder to face the fact that we are losing thousands of others to cancer because maximum advantage is not being taken of the tools we already have in hand, such as the "Pap" smear technique for detecting early, curable cancer of the uterus.



physician's bookshelf

BOOKS RECEIVED

Silver, Henry K., M.D.; Kempe, C. Henry, M.D., and Bruyn, Henry B., M.D., **HANDBOOK OF PEDIATRICS**, Lange Medical Publications, Los Altos, Calif., 1961, 574 pp., \$3.50.

Wolstenholme, G.E.W., O.B.E. and O'Connor, Maeve, B.A., **CIBA FOUNDATION SYMPOSIUM NO. 6, METABOLIC EFFECTS OF ADRENAL HORMONES**, Little, Brown and Co., Boston, Mass., 1960, 109 pp.

Wilson, John L., M.D. and McDonald, Joseph J., M.D., **HANDBOOK OF SURGERY**, Lange Medical Publications, Los Altos, Calif., 1960, 644 pp., \$4.00.

Wolstenholme, G.E.W., O.B.E. and O'Connor, Maeve, B.A., **CIBA FOUNDATION SYMPOSIUM ON ADRENERGIC MECHANISMS**, Little, Brown and Co., Boston, Mass., 1960, 632 pp., \$12.50.

Trowell, H. C., O.B.E., M.D., **NON-INFECTIVE DISEASE IN AFRICA**, Williams and Wilkins Co., Baltimore, Md., 1960, 481 pp., \$13.00.

Pillsbury, Donald M., M.D.; Shelley, Walter B., M.D., and Kligman, Albert M., M.D., **A MANUAL OF CUTANEOUS MEDICINE**, W. B. Saunders Co., Philadelphia, Pa., 1961, 430 pp., \$9.50.

Bock, K. D. and Cottier, P. T., **ESSENTIAL HYPERTENSION**, Springer-Verlag, Berlin, Germany, 1960, 392 pp.

White, Abraham G., M.D., **CLINICAL DISTURBANCES OF RENAL FUNCTION**, W. B. Saunders Co., Philadelphia, Pa., 1961, 468 pp., \$10.50.

MacDonald, Phyllis, **THE GOLDEN AGE COOKBOOK**, Doubleday and Co., Inc., Garden City, N. Y., 1961, 192 pp., \$2.95.

Gray, Madeline, **THE CHANGING YEARS**, Doubleday and Co., Inc., Garden City, N. Y., 1958, 273 pp., \$0.95.

Chu-Chiang, Liu, **INTROVERSIVE CENTRIPETAL CONTRACTION PHYSIOTHERAPY**, Physiotherapy Correspondence School, Taipei, Taiwan, Republic of China, 1961, 51 pp.

Rossmann, I. J., M.D. and Schwartz, Doris R., R.N., **THE FAMILY HANDBOOK OF HOME NURSING AND MEDICAL CARE**, Doubleday and Co., Inc., Garden City, N. Y., 1958, 519 pp., \$1.45.

REVIEWS

Wolstenholme, G.E.W., O.B.E., M.A., M.D., M.R.C.P., and O'Connor, Cecilia M., B.Sc., **CIBA FOUNDATION SYMPOSIUM ON CONGENITAL MALFORMATIONS**, Little, Brown and Co., Boston, Mass., 1960, 308 pp., \$9.00.

THIS VOLUME on experimental congenital malformations represents another of Ciba's valuable contributions toward increasing and disseminating medical knowledge. This is one of more than 20 symposia with the same general format, each of which consists of chapters containing a discourse on some subject by a well-known world authority, followed by an edited

discussion of this subject by the author and several other interested and informed participants.

The symposium on congenital malformations includes 13 chapters which cover the major known factors causing congenital anomalies: genetic, environmental, and experimental. Several specific anomalies are discussed at length. About half the chapters are concerned with humans and about half to experimental animals. One significant feature of this treatise is its rather thorough discussions of the abortive and teratogenic activity of many of the drugs now used in cancer chemotherapy. Those interested in this field will find valuable information here.

There are numerous references listed after each article. The author and subject indexes are quite adequate. This is an easily read book that should be available through hospital and university libraries to all who are interested in the subject, but will find a limited demand for private purchase.

John Rhodes Haverty, M.D.

Reynolds, Fred C., M.D., **THE AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS INSTRUCTIONAL COURSE LECTURES**, Vol. XVII, 1960.

THE AMERICAN ACADEMY of Orthopaedic Surgeons presents each year at its annual meeting a series of instructional courses. The participants are carefully selected and well qualified.

This excellent volume is divided into five parts containing a total of 26 lectures. Fractures, bone graft surgery, children's orthopaedics, athletic injuries, and a section devoted to miscellaneous topics comprise the contents of this book. The illustrations are superior and each author has an adequate bibliography.

The section on bone graft surgery is perhaps the most informative. Particularly impressive is a well written and comprehensive review of this subject by Boyd and Lipinski of the Campbell Clinic.

Blount and Green have again given a masterly review of the causes and treatment of leg length inequality. The lecture by Aitken & Frantz on management of the child amputee serves as a reminder that there are many differences between the juvenile and the adult amputee. Of particular interest to all who are interested in athletic injuries is the symposium on this topic by such outstanding contributors as O'Donoghue, Brewer, Slocum, and Quigley.

This book represents the well organized efforts of Dr. Fred C. Reynolds and his associates as well as the

publisher. There will be many orthopaedic surgeons, including this reviewer, who will wish to add this volume to their library.

Wood W. Lovell, M.D.

Wolstenholme, G. E. W., O.B.E., and O'Connor, Cecilia M., B.Sc., Ciba Foundation Colloquia on Endocrinology, Volume XIII, HUMAN PITUITARY HORMONES, Little, Brown & Co., Boston, Mass.

"HUMAN PITUITARY HORMONES" is the 13th volume in a series of published proceedings of the Ciba Foundation of Colloquia on Endocrinology. The papers printed here and the discussion took place in August, 1959, at a conference held in Buenos Aires in honor of the Noble Laureate, Bernardo A. Houssay. The material under the discussion is just now reaching the point of publication in the medical literature.

The participants represents 32 of the world's leading investigators of the physiology of the pituitary gland, of which two are Georgians. Possibly as a result of the influence of Doctor Houssay, at least one-half of the book is devoted to considerations of growth hormone.

Of particular interest is the discussion by Doctor C. H. Read, of the State University of Iowa. Doctor Read and his collaborators have developed a technique for measuring growth hormone in the blood of human beings by immunological approaches. Doctor Read outlines the background of his studies and the methodology involved. The immunologic quantitation of both hormones will certainly be more widely discussed in the months to come.

Doctors M. S. Raben and C. H. Hollenberg, of Tufts University, discuss the role of growth hormone in the mobilization of fatty acids. These workers were able to show that administration of growth hormone increases the circulating free fatty acids in the plasma of human subjects. A discussion is presented of the many different factors which are brought to play on the mobilization of free fatty acids from the fat depots,

including hyperthyroidism, starvation, fever, and epinephrine release.

Doctors G. F. Joplin and Russell Fraser, of the Postgraduate Medical School of London, discuss the radiological anatomy of the human pituitary fossa. The importance of this study revolves around the increased use of the implantation of Yttrium-90 in the pituitary fossa as a means of ablating the pituitary gland or pituitary tumors.

This book will not find wide acceptance as a source of information for use in the practice of medicine. The serious student of endocrine physiology will find it useful as a reference source. Most physicians will enjoy reading bits of the book because of the freshness and originality of the material presented. The reader has the feeling that he is confronted with physiological data which, while of pioneering nature at the moment, will be incorporated in his clinical thinking within the next ten to 12 years.

Roy A. Wiggins, Jr., M.D.

NOTE

W. B. SAUNDERS COMPANY features the following recent books in their full page advertisement appearing elsewhere in this issue:

WHITE—"Clinical Disturbances of Renal Function"

Diagnosis and treatment measures for kidney disorders.

RUBIN—"Thoracic Diseases"

Covers both medical and surgical management.

MAYO CLINIC—"Diet Manual"

Recent advances in food, vitamin and dietary practice.

THE PHYSICIAN'S ROLE IN THE SOCIAL SECURITY DISABILITY DETERMINATION

DISABILITY IS DEFINED by the social security law as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to be of indefinite duration, or to result in death. The disability determination is made by an agency of the State—usually the Vocational Rehabilitation Agency—in which the worker resides. In Georgia the Division of Vocational Rehabilitation makes the determinations. The keystone to the disability decision is the doctor's medical report describing the patient's impairment and how it affects his remaining functional capacities.

The medical report should give the history, symptomatology, clinical findings, and diagnosis in sufficient detail to permit the physician member of the State agency evaluation team to arrive at an independent evaluation of the patient's remaining functional capacities. The report should contain specific information about clinical findings and diagnoses. For example, in giving details about a heart patient, specific data, such as cardiac size, EKG findings, the amount of dyspnea

or angina, and classifications established by the American Heart Association, are far more useful than general descriptions such as mild, moderate, or severe. If available, the report should also furnish information about the patient's condition at the time he first became unable to work. It should be noted that the physician is asked to provide objective medical data only. He is not put in the position of having to determine whether the patient is "disabled" under the terms of the law.

A film entitled, "The Disability Decision" has been prepared by the Bureau of Old-Age and Survivors Insurance in cooperation with the American Medical Association. The film illustrates the importance of the medical report and the doctor's role in the disability insurance program. To arrange for a showing of the film to your group, contact the Social Security district office or the Vocational Rehabilitation office in your community. They will be glad to show the film without cost and provide further information about the Social Security disability program.



mental health page

PEPTIC ULCER

J. Frank Harris, M.D., *Atlanta*

MOST PRACTICING PHYSICIANS and their patients readily agree to the close association between nervousness and stomach trouble. "He (or she) makes me sick at my stomach" . . . "That gripes me" . . . "I was so upset that I vomited all night" . . . these are common medical recitations. That actual ulceration of the peptic mucosa can and does occur as a result of stress (strain or failure of the individuals adaptive mechanisms) is no longer doubted. However, many mute and obscure physiological mechanisms still exist. Oversecretion of hydrochloric acid, hypermotility of the gut, deficient mucosal blood supply from any cause, and increase in lysozyme all seem to be implicated in the production of peptic ulcer. Adrenal cortical hormones and their injudicious use are known to cause or reactivate ulcer. It is reported that peptic ulcer can co-exist with hyperparathyroidism, cirrhosis of the liver, and certain central nervous system lesions.

Many point to the infinite capacity of modern day man to dissipate both his talents and energies as "ulcerogenic" . . . the 20th century rat race runs daily in all directions with the spectre of a mushroom-shaped cloud as a backdrop! The continuous getting and striving for things of evanescent, materialistic value, and without taking time for proper leisure, fun, and contemplation can be traumatic for some individuals.

The personality profile of the "typical" ulcer patient often includes such traits as sensitive, tense, hard-working, and overly ambitious. Quick to anger and aggravation with themselves, other people, and things, he experiences difficulty in venting his feel-

ings, and, instead, holds them inside (the stomach and duodenum). Often he reaps not the rewards but the penalties of perseverance.

At least 85 per cent of peptic ulcer can be demonstrated by x-ray examination; gastric ulcer may be visualized by gastroscopy, but not duodenal ulcer because of its inaccessibility. The physician may choose to treat on the basis of the characteristic history of epigastric pain and discomfort (often well-localized), burning, and relief of symptoms by food and anacids. Traditional therapy with antispasmodics, anacids, and bland diet is usually successful in, say, simple duodenal ulcer, but gastric ulcer requires tedious evaluation in order that neoplastic disease be ruled in or out.

Instructing the mature male in the virtues and necessities of a bland diet often evoke both his resentment and hostility. Deprived of his usual free choice of food, he becomes rebellious at his wife for feeding him mushy "baby food" and milk, at his physician for prescribing it, and at himself for being sick in the first place! Dietary instructions can be given objectively as, "This is the diet found to be most helpful in patients with your disease," rather than, "This is the diet I want you to eat." Present day dietary instructions permit a more liberal choice of foods . . . a welcome change from the rigors of the early Sippy regimens. The patient should understand fully that peptic ulcer tends to be a chronic, recurrent disease frequently affecting the individual with a certain personality matrix. He should be allowed to maintain sufficient anxiety about his disease to be mindful of the seriousness of

hemorrhage, perforation, and obstruction which may result from no treatment or improper treatment.

Well-meaning admonitions to "take it easy, slow down, and relax" are often ineffective even in the restricted environment of a hospital. With some improvement in his symptoms, however, the time for continuing care may be at hand. Now more receptive and optimistic, he should explore and evaluate possible etiologic factors in his life situation. Ideally the patient should capitalize on some

of the "ulcer traits" by rechanneling them into conscientious attention to medication, diet, and the changing of traumatic habits. He may find that the conquest of aggravation is the most important part of therapy, and the following outline may be helpful:

1. Avoid it . . . do not engage in needless combat
2. Express it . . . say what you think to someone
3. Work it off . . . physical activity, sports, hobbies, etc.
4. Changing basic attitudes . . . listen to the other persons viewpoint.

REDUCTION OF FOREIGN MEDICAL GRADUATES

REDUCTION IN THE NUMBER of foreign medical graduates in this country has little to do with the growing number of unfilled hospital staff positions, a former medical school dean said recently.

The unfilled positions result because more internships and residencies have been approved than are really needed or can actually be filled—and not because the number of foreign graduates is decreasing, Willard C. Rappleye, M.D., said in *Hospitals*, Journal of the American Hospital Association.

Dr. Rappleye, now president of the Josiah Macy Jr. Foundation, New York, was formerly dean of Columbia University College of Physicians and Surgeons.

A program to require foreign medical graduates to pass an examination given by the Educational Council for Foreign Medical Graduates is now in effect and has produced the charge that its implementation will produce a deficit in the number of physicians available to fill house staff positions in United States hospitals.

Approximately 12,000 foreign graduates now occupy about 33 per cent of the house staff positions in the country, he said.

The Educational Council for Foreign Graduates, supported by several major medical, hospital, and health organizations, was set up to promote educational opportunities for foreign graduates and to make sure that they reach a level of attainment comparable to graduates of United States schools.

Qualification tests have been given at intervals both in the United States and abroad. The most recent test in September 1960, was taken by 8,713 graduates, of whom 71 per cent were certified.

The American Medical Association and the American Hospital Association ruled that as of December 31, 1960, hospitals must remove unlicensed or uncertified graduates from patient care situations or face loss of approvals. The physicians who were removed from patient

care situations could have taken the next examination, which was scheduled for April 4. Many hospitals set up educational courses for these physicians, with the aim of preparing them for the examination.

The real problem of house staff positions lies in the fact that the number of available internships (13,032) and residencies (30,733) far exceeds the number of graduates of American medical schools (7,081 in 1960). And too many of the positions, according to Dr. Rappleye, are now "intended and designed more as service functions for the staff and hospital than for education purposes," their real function.

Internship and residency programs must be turned into real educational programs—both for graduates of American and foreign medical schools. The programs for foreign graduates urgently need "a long-term, imaginative approach," especially in terms of meeting America's promises of aid to underdeveloped countries, he continued.

Most foreign graduates are expected to return home, where they will organize and improve medical education and service. Thus their educational programs here should be geared to such an aim, Dr. Rappleye said.

The over-all question of staffing American hospitals must also be solved. Temporarily, it may be necessary for hospitals to set up rotating programs whereby the attending physicians remain on call for the entire hospital on weekends and nights.

The most logical solution to the problem, Dr. Rappleye believes, is "probably employment of well qualified recent graduates on a full-time or part-time basis by the hospitals." Such young physicians can remain in the positions for several years while establishing themselves in the community.

By having such staff members, the intern and residency programs can then become truly educational programs, he said.



heart page

THE TREATMENT OF REFRACTORY HEART FAILURE

Waddell Barnes, M.D., *Macon*

EVERY PHYSICIAN IS, at times, confronted with a patient having an especially obdurate congestive heart failure problem. Naturally the temptation is great to assume that this merely represents the terminal, untreatable, end result of whatever heart disease the patient is presumed to have suffered. In point of fact this is sometimes true, but the bland assumption without absolute proof can represent a grave error in patient management, and can be disastrous to the individual concerned.

The first problem in evaluation of the future therapeutic course is proof of the presumed specific etiologic diagnosis of the heart disease. Because of their relative preponderance, it is often surmised that all cases of adult heart failure are due to rheumatic fever, to hypertension, or to coronary artery disease. When the physician is confronted with a patient not having the usual stigmata of these diseases, the patient is somehow wormed into one of these classifications through some selfsubterfuge on the part of the physician. This attitude is, of course, aided by the fact that in some cases of hypertensive cardiovascular disease the blood pressure will drop to normal with the advent of failure. Also the proof of coronary artery disease and of its relationship to the congestive heart failure can sometimes be exceedingly difficult especially if the classical criteria for such a diagnosis is rigidly followed. The search for the specific cause of heart failure often requires the height of diagnostic acumen. A careful elicitation of the history, and a meticulous examination of the patient are prerequisites. The doctor must be especially careful to consider specific treatable diseases, such as thyrotoxic heart disease,

myxedema heart disease, beri beri, and pericarditis. Also, unless the patient is considered as a whole, the physician will miss the diagnosis of an AV fistula, chronic lung disease with secondary cor pulmonale, Paget's disease, and other extra cardiac causes of congestive heart failure.

Other than being refractory because of the inherent nature of the lesion, the refractoriness might well be due to some complication that has nothing to do with the heart, such as pneumonia, recurrent pulmonary emboli, pyelonephritis, or some other obscure problem. Rhythm disturbances with their consequent decrease in cardiac output must be controlled if possible.

Sometimes the heart failure is stubborn because of an exaggeration of the normal adaptive mechanism. Examples of this cause are the pulmonary hypertension consequent to cyanosis in the patient with chronic lung disease, a secondary polycythemia with consequent increase in blood viscosity, hypervolemia, or an inordinate increase in salt retaining hormone secretion. Each of these features is, to some extent, remediable, and attention should be given to them as possibilities.

Assuming that all of the above factors have been eliminated several considerations remain. Physical and perhaps emotional overactivity must be viewed as possibilities which precipitated the refractory failure. The age old treatment of insistence upon adequate rest is commonly ignored by both the physician and the patient, probably because of the present absolute faith in miracle drugs.

Proper regulation of the patient's digitalis dosage must come under scrutiny. Despite their wide popu-

larity, some of our currently used oral digitalis preparations are fairly difficult to use in day to day regulation of cardiac patients. Digoxin has been especially criticized for these purposes because of its relatively short duration of action. Consequently the patient may be underdigitalized. Realization that both underdigitalization and overdigitalization can precipitate a refractory heart failure, the physician must be as certain as possible that the patient is optimally digitalized, even if this means pushing digitalis to early toxicity for proof of optimal drug effect.

Intractable edema may be a part of the "sick cell syndrome," but a fluid or an electrolyte imbalance can be caused by the drug administered by the physicians as well as being inherent in the nature of congestive heart failure. Of these drugs the most common offender is of course the diuretic agent. Mercurial diuretics cause primarily a choride diuresis and hence a hypochloremic alkalosis at times results in a peculiar obstinancy to their diuretic action. At times an excessive loss of potassium and even sodium without a proportionate water loss is seen,

especially with chlorothiazide derivatives. Careful evaluation of the electrolyte composition of the serum and consideration of the patient's total fluid and electrolyte balance may help to achieve a therapeutic effect from diuretics. Also it should be noted that none of the above diuretics is primarily a stimulant to water loss, and the possibility of simple water intake restriction should be entertained. Paradoxically diuretic refractoriness is sometimes lessened by the use of cortisone derivatives, but at present the indications for the administration of these substances to persons in refractory failure are nebulous, and most published results seem to indicate that the majority of the cases of refractory failure are not benefited by cortisone derivatives. The status of aldosterone antagonists is equally obscure. It may be said that not all cases of heart failure exhibit an increased aldosterone secretion as measured by present techniques. Also aldosterone antagonists are relatively weak diuretics and their administration is expensive. In general, only minor benefit is accrued from the use of these agents.

From the above summary it may be seen that the therapy of refractory heart failure represents merely the reiteration of the principles of the careful practice of medicine.

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current clinical concepts

Routine Use of The Carlen's Double Lumen Endobronchial Catheter: An Experimental and Clinical Study

THIS CARLEN'S CATHETER was emphasized as being most useful when there was excessive bleeding and/or secretions had to be managed. However, the authors report that the catheter had been used for all adult pulmonary resections (200 consecutive patients) and certain other intrapleural procedures for the past two years.

Newman, Robert W.; Finer, George E., and Downs, James E., Knoxville, Tenn.: Routine Use of the Carlen's Double Lumen Endobronchial Catheter: An Experimental and Clinical Study, presented at the American Association for Thoracic Surgery, April 24-26, 1961, Philadelphia, Pa.

The Surgical Management of Metastatic Neoplasm in the Lung

IN THE YEARS between 1933-1960, 67 patients have undergone surgical excision of metastatic pulmonary disease. The majority of these have been primary in the colon or kidney, but origins in various other organs are recognized. Survival figures for 100 per cent of these patients indicate a cumulative survival curve not unlike that for primary carcinoma of the lung. Carcinomatous metastases from the breast and melanomas have poor follow-ups.

Wilkins, Earle W., Jr.; Burke, John F., and Head, John M., Boston, Mass.: The Surgical Management of Metastatic Neoplasm in the Lung, presented at the American Association for Thoracic Surgery, April 24-26, 1961, Philadelphia, Pa.

Traumatic Tracheal Rupture

TRAUMATIC TRACHEAL rupture, due chiefly to sharply localized blunt trauma to the upper anterior

cheek and neck, is being recognized with increasing frequency. The treatment is usually urgent tracheostomy to alleviate the symptoms of subcutaneous emphysema and choking. The advantages for immediate surgical repair of the torn trachea in preventing stenosis, preserving a normal voice, and eliminating a prolonged period of invalidism are stressed.

Shaw, Robert R.; Paulson, Donald L.; Kee, John L., Jr., Dallas, Texas: Traumatic Tracheal Rupture, presented at the American Association for Thoracic Surgery, April 24-26, 1961, Philadelphia, Pa.

Bronchiolar Cell Carcinoma of the Lung

THIRTY-THREE CASES were reported on with 17 males and 16 females whose age ranged anywhere from 37 to 82. The emphasis is that the x-ray is the key to making the diagnosis. Five patients were alive and well from 16 to 45 months. X-ray therapy was thought to be of little value. The emphasis again is to do as early surgery as possible in order to promote a longer follow up in these patients that are operable.

Fitzpatrick, Hugh F.; Miller, Robert E.; Edgar, Malcolm S., Jr., and Begg, Charles F., New York, N. Y.: Bronchiolar Cell Carcinoma of the Lung: A Review of 33 Patients, presented at the American Association for Thoracic Surgery, April 24-26, 1961, Philadelphia, Pa.

Complete Functional Restitution of the Food Passage in Extensive Stenosing Caustic Burns

CAUSTIC BURNS involving the upper food passage have long posed insuperable surgical problems. Stenosis of the hypopharynx, cricopharyngeus pinch-cock, and esophagus, have usually resulted in the tragedy of permanent gastrostomy. The technique

CLINICAL CONCEPTS / Continued

was described in which the right colon has been brought up to the pharynx with eminently satisfactory results in a significant series of cases done. It was emphasized that the right colon appears to be best in benign lesions of the esophagus; the jejunum in the lower benign lesions of the esophagus. They recommended that perhaps the stomach be used where carcinoma involved the esophagus.

Ogura, Joseph H.; Roper, Charles L., and Buford, Thomas H., St. Louis, Mo.: Complete Functional Restitution of the Food Passage in Extensive Stenosing Caustic Burns, presented at the American Association for Thoracic Surgery, April 24-26, 1961, Philadelphia, Pa.

Calcium and Phosphorus Metabolism

FOR A BETTER UNDERSTANDING of some of the factors involved in kidney stone formation, this article should prove of interest and value to Georgia physicians whose patients live in an area whose incidence of kidney stone formation ranks with the highest in the world.

Fraser, Donald, M.D.: Calcium and Phosphorus Metabolism, J.A.M.A., Vol. 176, No. 4, April 29, 1961.

Villous Tumors of the Rectum and Colon Characterized by Severe Fluid and Electrolyte Loss

DIVERSION OF URINE to the gastrointestinal tract has become increasingly popular, but such pro-

cedures must not be undertaken lightly. If a sufficiently large area of mucosa of the bowel is exposed to urine, one can expect, among other difficulties, the development of hyperchloremic acidosis.

Shnitka, Theodor K.; Friedman, M.H.W.; Kidd, Edward G.; MacKenzie, Walter C.: Villous Tumors of the Rectum and Colon Characterized by Severe Fluid and Electrolyte Loss, S. G. & O., Vol. 112, No. 5, May, 1961.

Novobiocin and Hyperbilirubinemia

DURING NOVOBIOCIN THERAPY for a nursery staph outbreak, there occurred a three-fold increase in the number of clinically jaundiced neonates. Indirect-reacting bilirubin levels were elevated. Presumably, novobiocin could interfere with bilirubin metabolism by enzymatic blockade, but the manner in which this may occur is unknown.

Sutherland, J. M. and Keller, W. H.: Novobiocin and Hyperbilirubinemia, Am. Dis. Child. 101:447, 1961.

Closed Chest Cardiac Resuscitation

IT IS ABSOLUTELY essential that every physician learn the technique of closed chest cardiac resuscitation. This technique obviates the disadvantages of open massage and may, in fact, be a lifesaving measure in the patient who has circulatory arrest outside the hospital. This technique, coupled with mouth-to-mouth ventilation, should replace other forms of resuscitation, and result in the saving of many lives.

Bahnsen, Henry T.: Closed Chest Cardiac Resuscitation, S. G. & O., Vol. 112, No. 5, May, 1961.

NEW APPOINTMENTS AT BRAWNER'S SANITARIUM

JAMES N. BRAWNER, JR., M.D. Medical Director of Brawner's Sanitarium at Smyrna, announces several recent additions to the hospital staff in the practice of psychiatry and related fields of psychological medicine.

Dr. Mary H. Elliott, a native of England and graduate of Oxford University Medical School, is an associate in psychiatry and child psychiatry. Dr. Elliott received her specialty training at the Institute of Living, Hartford, Conn., the Connecticut State Hospital at Middletown, and as a Fellow in child psychiatry for two years at the North Carolina Memorial Hospital, Chapel Hill, N. C.

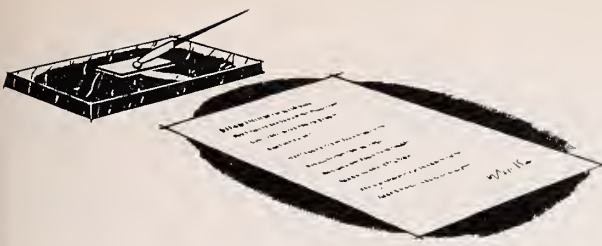
Dr. Aloysius I. Miller, also an associate in psychiatry, is a former resident of Atlanta. He received his B.A. degree at the University of Buffalo, his M.A. from Emory University and Emory University Medical School; Ph.D. in anatomy and histochemistry in 1953, and M.D. degree in 1954. He completed his residency training in psychiatry at the Georgetown University Hospital in Washington D. C. in 1960. Since then Dr. Miller was Assistant Professor of Psychiatry, Georgetown Uni-

versity Medical School and Director of Research in Psychiatry at the District of Columbia General Hospital.

Dr. Frances Valasek, assistant in psychological medicine, is a native of Minnesota. She received her A.B., M.A., and M.D. degrees at the University of Minnesota and was Research Assistant with the Mental Health Division of the Georgia Department of Public Health prior to joining the staff at Brawner's in November 1960.

Dr. Gene Nardin, resident physician and internist, received his A.B. from Emory University and is a graduate of Emory University Medical School. He received his training in internal medicine at Emory University Hospital.

Brawner's Sanitarium celebrated its 50th Anniversary in 1960 and in 1959 full approval was given by the Central Inspection Board of the American Psychiatric Association and the Joint Commission on Accreditation of Hospitals.



Galambos, John T., Emory University Hospital, Atlanta, Georgia, "Evaluation of the Jaundiced Patient in the Postoperative Period," *South. M. J.* 53:1263-1267 (Oct. Patients who developed jaundice following a surgical procedure may be classified in four major groups according to the etiology of their jaundice. (1) It may be related to the disease which require operation in the first place, (2) it is secondary to the various therapeutic measures, (3) the cause of jaundice may not be directly related to either 1 or 2, but it may have been precipitated by a metabolic stress of the operative intervention, and (4) the jaundice is unrelated to the operation altogether. The usefulness of various clinical and laboratory observations are discussed in the paper, which would direct the physician for the correct diagnosis and help him initiate the appropriate therapeutic measures.

McDonald, Harold P., M.D., 272 Ivy Street, N.E., Atlanta 3, Georgia, "Transurethral Resection of Tumors of the Bladder: Indications and Technic," *J. Internat. Coll. Surgeons* 35:9-20 (Jan.) 1961.

This paper is concerned with the advantages of transurethral resection as the method of choice in dealing with tumors of the bladder. The incidence of tumors of the bladder as well as the location of such tumors is described. It is pointed out that when bladder tumors are seen at an early stage and before invasion through the bladder muscle has occurred, it is possible to remove the entire tumor transurethraly. It is preferred that this be done with a resectoscope and that after resecting all of the tumor coagulation of the base and surrounding edge of the bladder wall be accomplished. A special loop is demonstrated for removal of tumors on the posterior wall of the bladder. Emphasis is placed on early diagnosis and complete resection of tumors coupled with a diligent follow-up schedule for two years, after which the time interval for follow-up cystoscopic examinations is lengthened to two times a year. This schedule is continued indefinitely.

Engel, Marvin F., M.D., 2001 Gloucester Street, Brunswick, Georgia, and Smith, J. Graham, Jr., M.D., Durham, N. C., "The Pathogenesis of Necrobiosis Lipoidica," *Arch. Der.* 82:791-797 (Nov.) 1960.

The presence of antigenically identical protein substances in the serum of

diabetic patients with vascular complication and in patients with necrobiosis lipoidica diabetorum without diabetes was demonstrated using the complex double-diffusion agar gel technique of Ouchterlony. This substance, or substances, was shown to be absent from the sera of normal individuals and from the sera of diabetics without clinically detectable vascular disease.

This finding, plus the previous demonstration of mucopolysaccharide in the affected vessels in both diabetic patients and in patients with necrobiosis lipoidica diabetorum without diabetes, and the comparable changes in the blood proteins, i.e., elevated alpha two globulin, alpha two glycoprotein, and total protein-bound hexose (TPBH), led the authors to postulate that necrobiosis lipoidica diabetorum is a form fruste of diabetes mellitus.

Olansky, Sidney, M.D., Emory University Clinic, Atlanta 22, Georgia, "Cutaneous Manifestations of Primary and Secondary Syphilis," *Postgraduate Med.* 28:510-514 (Nov.) 1960.

Early syphilis, i.e., primary and secondary syphilis, is infectious. These stages can be diagnosed with the greatest accuracy by demonstrating the presence of the causative organism, *T. pallidum*, by dark-field examination.

Primary syphilis causes genital or extragenital lesions; secondary syphilis causes skin eruptions, which are usually generalized; mucosal lesions; loss of hair; or iritis. Primary syphilis may or may not be associated with a reactive S.T.S.; secondary syphilis always is.

It is most important to diagnose early syphilis, because treatment at this stage offers the best chance of cure to the patient and prevents the development of serious manifestations of the disease. The early stages of the disease also afford the best opportunity for diagnosis. The possibility that the patient has early syphilis can be ruled out quite easily and quickly. One merely has to examine all of the skin and the orifices of the patient. If lesions exist, a dark-field examination and serologic tests for syphilis can be done. The diagnosis presents little difficulty, if the proper tests are performed. Early diagnosis offers the best chance for the patient (cure), the best chance for the community (epidemiology), and is most rewarding to the physician, since few other diseases have such an excellent prognosis when adequate treatment is given.

Schubert, Joseph H., Ph. D.; Eleff, M. G., M.D., and Hermann, George J., M.S. Laboratory Branch, C.D.C., Chamblee, Georgia, "Hemagglutination Test for Pertussis Antibody with a Soluble Extract of Bordetella Pertussis," *Am. J. Pub. Health* 51: 441-445 (March) 1961.

Pertussis antibodies were detected with tanned sheep erythrocytes sensitized with an extract of the pertussis organism. The harvested pertussis organism was stored at -20° C. and extracted with a mixture of thiourea, urea, and formamide as needed.

A study of 44 individuals, given a series of three injections, showed an increase in titer after immunization. Blood from immunized infants tested at three months of age had titers of 2,048 to 4,096, whereas the cord blood titers or the mothers' serum titers were eight or less. Non-immunized mothers generally do not have an antibody titer and, accordingly, antibodies are not available for transmission to the infant.

Schroder, J. Spalding, M.D., Emory University Hospital, Atlanta, Georgia, "Protein-Losing Gastroenteropathy," *South M.J.* 54:249-252 (March) 1961.

Weeping giant folds of gastric mucosa shed "tears of albumin" resulting in hypoproteinemia of sufficient degree to produce massive anasarca. There may be abdominal cramps, nausea, vomiting, and diarrhea. The giant hypertrophy of the gastric mucosa, with pseudotumor formation, may lead to radiologic impression of lymphosarcoma until the syndrome is suspected.

The protein is rapidly digested by gastrointestinal enzymes, and reabsorption of amino acids occurs. Radio-iodinated serum albumin is thus unable to be recovered from feces or quantitatively from gastric suction. I-131 labelled P.V.P. (polyvinylpyrrolidone) may be administered intravenously and is recoverable in increased amounts from stools indicating an abnormal permeability of the gastrointestinal tract to macromolecules.

The cause of syndrome is unknown. A hypersensitivity phenomenon is suspected in some cases. Gastrectomy has been resorted to in some cases with prompt cure. Spontaneous remission has occurred in others.

This syndrome may account for many cases previously diagnosed "hypercatabolic," "idiopathic" or "essential" hypoproteinemia.

Case Report: A 10-year old white male developed unexplained anasarca, vomiting, and progressive anasarca

ABSTRACTS / Continued

seven weeks after repair of interatrial septal defect using extracorporeal circulation. Laboratory studies revealed hypoalbuminemia. Vomitus was described as resembling "egg-white." G.I. series revealed markedly hypertrophied gastric folds, interpreted as probable gastric neoplasm. Gastrosocopy revealed hypertrophied gastric rugae with no ulcerations. Biopsy of gastric mucosa revealed findings consistent with Menetrier's Disease. He recovered spontaneously, has had no recurrence, and follow-up G.I. series is normal.

Rhode, C. Martin, M.D., V.A. Hospital, Augusta, Georgia, "Treatment of Hand Infections," *Am. Surgeon* 27:85-115 (February) 1961.

There is an increasing number of patients hospitalized at our institution with significant infections of the hand. Some of these infections are quite virulent and destructive in spite of, or as a result of antibiotic therapy.

The severe handicap of a hand, limited in motion and function, is more fully appreciated by those who have experienced such malfunction and the surgeons who see and treat these patients.

Thorough knowledge of the anatomy of the hand is all important for early and accurate diagnosis and proper treatment. The resistive nature of the palmar fascia, the fascial septae of the finger tips or pulps and fascial tendon sheaths; the volar spaces within the tendon sheaths, lumbrical muscle fascia, and the two deep fascial palmar spaces.

The causative organism in all of these cases was coagulase positive staphylococcus in pure form. The amount of

necrosis caused by this organism in each patient was more extensive than might be originally suspected and all were associated with pus formation.

Surgery was required in each of these cases. Incision and drainage may suffice. In most of our cases, however, adequate incision has revealed a substantially larger area of subcutaneous and deeper tissues involved in a necrotizing process.

Judicious, radical debridement was carried out at the initial incision, carefully removing all overtly necrotic skin, subcutaneous, and fascial tissue. Should the viability of more vital structures, such as tendons, be at all in question, more conservatism is exercised; if frankly necrotic, these structures are likewise debrided at the first sitting. Such early adequate surgical excision of devitalized tissues has permitted early secondary closure most often within five to seven days. At this time the wound is clean and readily accepts a split thickness skin graft if needed. Between operations the hand again is immobilized in the position of function.

When early closure is effected, a basic tenet is accomplished—conversion of an open contaminated or infected wound to a clean, closed one as quickly as possible. The avoidance of chronic drainage; prolonged edema, inflammation, and immobilization helps prevent the stiffness, fibrosis, adherence, and contractures—so disastrous to the mobile, precisely functioning hand.

Manchester, P. Thomas, Jr., M.D., 478 Peachtree Street N.E., Atlanta 8, Georgia, "Retinoblastoma Among Offspring of Adult Survivors," *Arch. Ophthalmol.* 65:546-549 (April) 1961.

Retinoblastoma is a malignant tumor of the retina which is sometimes known to be hereditary. When a child is found to have retinoblastoma and he is

curred by irradiation and/or enucleation of the eye he may reach maturity, marry, and have offspring. The present study was made to determine the incidence of retinoblastoma among the offspring of adult survivors of this disease. Thirty-six adult survivors were located during the study which continued between 1956 and 1961. Nineteen of these adults had children, there being 36 in all. Of the 36 children, 12 has retinoblastoma also.

Smith, Robert H., M.D.; Goodwin, Craig; Fowler, Edwin; Smith, George W., M.D.; and Perry Volpito, M.D., Medical College of Georgia, Augusta, Georgia, "Electronarcosis Produced by a Combination of Direct and Alternating Current," *Anesth.* 22:163-168 (March-April) 1961.

The Russian, Anan'ev, in a 1957 article in a journal of experimental surgery described an electrical current pattern and application which produced analgesia in animals. He employed direct current plus a square wave of alternating current, this wave being one millisecond in duration, and at a frequency of 100 per second.

We duplicated his results by the use of a generator capable of producing the effects described. We determined that the electrodes for current application, and the pattern of current application, were critical factors in the production of electronarcosis. The circuit for the generator, the pattern of current application, and the design and placement of the electrodes are described. Nine of eleven attempts to create total analgesia in dogs were successful. The analgesia was not accompanied by unconsciousness in dogs. The vital functions do not appear to be depressed. It appeared that more current than our generator produced would be required to produce electronarcosis in some dogs.

DERMATOLOGISTS ELECT NEW OFFICERS

THE GEORGIA SOCIETY of Dermatologists met Sunday morning, May 7, 1961 at Grady Memorial Hospital. After examining 16 interesting and unusual dermatological cases in the Dermatology Clinic collected by the Atlanta group, the members retired to the Hospital Auditorium for discussion of the cases with Dr. Ray Noojin of Birmingham, our guest speaker for the MAG Annual Session. At the business meeting that followed Dr. Vincent J. Cirincione, Savannah, was elected Chairman to succeed Dr. William L. Dobes, Atlanta,

and Dr. R. M. Reifler, Macon, was re-elected Secretary-Treasurer.

Sunday evening the members and wives met at the Piedmont Driving Club for a social hour and dinner. In the Georgian Ballroom, Atlanta Biltmore Hotel, on Monday morning, papers were given by Dr. Marvin F. Engel, Brunswick, on "Monilia Granuloma"; Dr. Ray O. Noojin, Birmingham, on "Precancerous Skin Lesions"; Dr. William L. Dobes, Atlanta, on "Psoriasis."

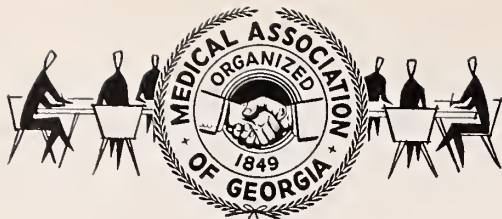
NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Amatryan, Fernando F.	300 Boulevard, N.E. Atlanta 12	DE-2	Fulton
Barraza, L. G.	1444 4th Ave. Columbus	Active	Muscogee
Chew, William H.	Talmadge Memorial Hosp. Augusta	DE-2	Richmond
Freeman, Malcolm G.	80 Butler St., S.E. Atlanta 3	DE-2	Fulton
Freeman, Olen I., Jr.	1181 Lee St., S.W. Atlanta 10	Active	Fulton
Hasenhuttl, Kurt R.	310 Doctors Bldg. Columbus	Active	Muscogee
Molnar, Edmund M.	1968 Peachtree Rd., N.E. Atlanta 9	DE-2	Fulton
Smith, Joel P., Jr.	340 Boulevard, N.E. Atlanta 12	DE-2	Fulton
Smith, Frank Q.	35 Linden Ave. Atlanta 5	DE-2	Fulton
Steele, John T.	Athens Gen. Hosp. Athens	Active	Crawford Long
Teabeaut, James R., II	Medical College of Ga. Augusta	Active	Richmond
Thompson, Frank F., Jr.	Clinic Ave. Carrollton	Active	Richmond
Thornton, Nancy	Medical College of Ga. Augusta	Active	Richmond
Turner, Richard J.	Coffe Bldg. Main St. Clayton	Active	Rabun
Valasek, Frances E.	2932 South Atlanta Rd. Smyrna	Active	Fulton
Wouters, Freerk W.	1327 Warren Williams Rd. Columbus	Active	Muscogee
Zuspan, Frederick Paul	Talmadge Memorial Hosp. Augusta	Active	Richmond

COMMUNIST TACTICS

"AS SOVIET POWER GROWS, there will be a greater aversion to Communist parties everywhere. So we must practice the techniques of withdrawal. Never appear in the foreground; let our friends do the work. We must always remember that one sympathizer is generally worth more than a dozen militant Communists. A university professor, who without being a party member lends himself to the interests of the Soviet Union, is worth more than 100 men with party cards. A writer of reputation, or a retired general, are worth more than 500 poor devils who don't know any better than to get themselves beaten up by the police. Every man has his value, his merit. The writer who, without being a party member, defends the Soviet Union, the union leader who is outside our ranks but defends Soviet international policy, is worth more than a thousand party members."

Georgi Dimitrov



the association

DEATHS

RALPH HILL CHANEY, 75, prominent Augustan, died May 3, in a local hospital after a short illness. He was a native of Northfield, Minnesota.

Dr. Chaney graduated from the University of Pennsylvania Medical School, Mayo Foundation, was a member of the A.O.A., Member of the Richmond County Medical Society, the Medical Association of Georgia, the American Medical Association, and a Fellow of the American College of Surgeons. He was also a member of the Augusta Rotary Club and the Church of the Good Shepherd.

From 1922 to 1932, he was professor of surgery at the Medical College of Georgia and in 1934 was clinical professor of surgery at the Medical College. He served as past president of the Medical Association of Georgia and the Augusta Civic Music Association.

Dr. Chaney was a veteran of World War I, when he was a lieutenant colonel in the Medical Corps. He wore the Victory Medal with five clasps.

Surviving are his wife, Mrs. Alma G. Chaney; a daughter, Mrs. John L. Johnson of Pompton Plains, N. J.; three sons, Lucian W. Chaney of Ann Arbor, Mich.; Dr. Rudolph E. Chaney of Long Beach, Calif., and Dr. Ralph H. Chaney of Toccoa.; a brother, Dr. Newcomb Chaney of Philadelphia, Pa.; a sister, Mrs. Gertrude Pye of Belmont, Mass., and 13 grandchildren.

ROBERT W. EILERS of Smyrna died at the age of 39 on May 4. He was born in Gillespie, Ill.

Dr. Eilers received his medical degree from Emory University Medical School and interned at Crawford W. Long Hospital. He spent three years with the Navy during World War II and has worked with the F.B.I. He was a member of the Lutheran Church of the Redeemer in Atlanta.

His survivors are: his wife, Mrs. Elaine S. Eilers;

sons, William Gregory Eilers and Terry Eilers; sisters, Mrs. George Galloway, Alameda, Calif., Mrs. Esther Hackney, Gillespie, Ill., and a brother, Orville J. Eilers, Decatur, Ill.

E. M. McDONALD, 80, died in Winder on March 25. Dr. McDonald was formerly of Jefferson, Georgia.

He received his medical degree from Emory University Medical School in 1907 and did his residency at Grady Memorial Hospital.

He belonged to the First Presbyterian Church of Winder.

Survivors include one daughter, Miss Sarah Frances McDonald of Decatur; one brother, W. M. McDonald of Jefferson, and three sisters, Mrs. R. D. Medlock of Duluth, Mrs. L. A. Richardson of Atlanta, and Mrs. H. L. Verner of Athens.

T. C. NASH of Philomath died in his home April 4. Dr. Nash was 65 and practiced for 41 years in that area.

He graduated from the Medical College of Georgia in 1922 and served his residency at Margaret Wright Hospital in Augusta.

Dr. Nash was chief of staff of Wills Memorial Hospital, Washington, Georgia, member of the American Medical Association, the Wilkes County Medical Society, chairman of the Oglethorpe County Board of Health, a director of the Rural Electric Association in Washington, a director in the Washington Loan Banking Company, and chairman of the Board of Deacons of the County Line Baptist Church.

He is survived by his wife, Mrs. Frances Dillard Nash of Philomath; a son Thomas Dillard Nash of Clearwater, Florida; a daughter, Mrs. Melvin Kopecky of Austin, Texas; three sisters, Mrs. Marshall Nelms of Philomath, Mrs. H. G. Callaway of Rayle, and Mrs. H. M. Callaway of Philomath, and a granddaughter.

J. H. WHITESIDE of Statesboro died April 19, at the age of 73.

Dr. Whiteside graduated from the Medical College of Georgia. He was an important member of the Presbyterian Church which he helped build in Statesboro. He was the first president of the Statesboro Rotary Club and also channeled his efforts through the local Chamber of Commerce.

Survivors are two daughters, Mrs. J. W. Keith, Jr., Statesboro, Mrs. W. T. Maxwell, Memphis, Tenn.; two sisters, Mrs. I. T. Goolsby, Elberton, Mrs. W. S. Nesbit, Woodruff, S. C.; five brothers, Charlie, Sr., Jack and Robert H. Whiteside, Elberton, W. T. Whiteside, Greenville, S. C., J. D. Whiteside, Atlanta, and six grandchildren.

SOCIETIES

The BALDWIN COUNTY MEDICAL SOCIETY commemorated Doctor's Day by placing flowers on the graves of doctors from their county.

The BIBB COUNTY MEDICAL SOCIETY met on March 6, 1961 in the Macon Hospital.

The CARROLL-DOUGLAS-HARALSON MEDICAL SOCIETY met at Tanner Memorial Hospital in Carrollton on March 6, 1961. The meeting featured a program centered around the topic "Social Security Disability Evaluation."

Fred Zuspan spoke to the CHATTOOGA MEDICAL SOCIETY in April, on developments in diuretics. After the talk the doctors and their wives had dinner at the Riegeldale Tavern.

The Luau was the place for the COBB COUNTY MEDICAL SOCIETY'S celebration of Doctor's Day, which was sponsored by their Auxiliary.

The COFFEE COUNTY MEDICAL SOCIETY and their Auxiliary observed Doctor's Day by wearing red carnations.

COWETA COUNTY MEDICAL SOCIETY met on April 11, 1961 at the Ranch House Motel and Restaurant in Newnan. Their guest speaker was Mr. Bill Merrill of G. D. Searle & Company.

A nautical theme filled the air when the DeKALB COUNTY MEDICAL SOCIETY and their wives celebrated Doctor's Day at the American Legion Club in Avondale.

Dr. Francis H. Watt of Tallahassee, Fla. and Norman Pursley of Augusta, spoke on different occasions in April to the DOUGHERTY COUNTY MEDICAL SOCIETY.

The FLOYD COUNTY MEDICAL SOCIETY met in the Floyd County Hospital on May 2, 1961.

The GEORGIA MEDICAL SOCIETY had James A. Kemp as a guest speaker during the month of April.

The Woman's Auxiliary to the GORDON COUNTY MEDICAL SOCIETY entertained their doctors with a dutch supper in honor of Doctor's Day.

The GEORGIA MEDICAL SOCIETY met on March 22, 1961 at the Jefferson Hotel in Louisville.

S. K. Brown spoke to them about several interesting cases of chest disease.

The JEFFERSON COUNTY MEDICAL SOCIETY met on March 22, 1961 at the Jefferson Hotel in Louisville. S. K. Brown spoke to them about several interesting cases of chest disease.

The newly elected officers of the NEWTON COUNTY MEDICAL SOCIETY are James W. Purcell, president; Thomas L. Crews, secretary and treasurer, and Jim Mitchell, vice-president.

For the month of April the OCONEE VALLEY MEDICAL SOCIETY had G. S. Hinton speak on "The Eye in General Practice."

The OCONEE VALLEY MEDICAL SOCIETY met in the Rebel Cellar in Madison on the second Thursday in April.

The RICHMOND COUNTY MEDICAL SOCIETY is working on several panel discussions that will be presented the first four Mondays in May. The topics include Mental Health, Heart, Cancer, and Menopause.

Fish was the order of the night when the SPALDING COUNTY MEDICAL SOCIETY and their Auxiliary celebrated Doctor's Day.

The STEPHENS COUNTY MEDICAL SOCIETY met on March 23, 1961 at the Stephens County Hospital.

The TIFT COUNTY MEDICAL SOCIETY paid tribute to Doctor's Day with their Auxiliary at a buffet dinner.

Members of the TROUP COUNTY MEDICAL SOCIETY were given red carnations to wear on Doctor's Day.

The Woman's Auxiliary to the UPSON COUNTY MEDICAL SOCIETY entertained the local physicians with a dinner at Hotel Upson in observance of Doctor's Day.

The WARE COUNTY MEDICAL SOCIETY had reports from the Medical Association of Georgia meeting in Macon, during the first week in May.

The May meeting of the WARE COUNTY MEDICAL SOCIETY was held at the Okefenokee Golf Club on May 4.

The members of WAYNE COUNTY MEDICAL SOCIETY were entertained at a shrimp supper on Doctor's Day.

The WILKES COUNTY MEDICAL SOCIETY held its March meeting at David's Restaurant. The guest speaker was George S. Hinton.

The deceased members of the WORTH COUNTY MEDICAL SOCIETY were remembered on Doctor's Day when their Auxiliary put flowers on their graves.

A. M. Deal of Statesboro is the new president of the FIRST DISTRICT MEDICAL SOCIETY. Other officers are Robert B. Gottschalk of Savannah, president-elect; L. H. Griffin, Claxton, vice president; David Robinson of Savannah, secretary; L. Frank Lovett, Statesboro, treasurer; Charles Emory Bohler of Brooklet, councilor, and William Simmons of Sylvania, vice councilor.

James H. Crowdis of Blakely has been named president of the **SECOND DISTRICT MEDICAL SOCIETY**. Other officers include: Laurier Hackett of Camilla, vice president; Julian B. Neel of Thomasville, Secretary-treasurer; George R. Dillinger, councilor, and Frank McKemie, Albany, vice councilor.

The **THIRD DISTRICT MEDICAL SOCIETY** met in Americus on April 13, and had William Moretz and Fred Zuspan speak. Both of these doctors are professors at the Medical College of Georgia.

John Lewis of Atlanta, spoke to the **FOURTH DISTRICT MEDICAL SOCIETY** April 12, held in Upson County.

The Laurens County Medical Society was host to the **SIXTH DISTRICT MEDICAL SOCIETY** held in Dublin.

PERSONALS

First District

BRUCE SAMS and Meyer M. Schneider of Savannah addressed the First District Meeting of the Georgia State Nurses Association in April.

IRVING VICTOR recently gave a pictorial talk on his trip to Holland and France to St. Joseph's staff in Savannah.

JAMES A. KEMP, Augusta, spoke to the Georgia Medical Society about autoimmunity in disease in April.

Pediatrician, HOWARD MORRISON moderated a film in May entitled "Why Won't Tommy Eat?" for the Chatham-Savannah Mental Health Association.

Some Savannah doctors attended the Georgia Heart Association in Atlanta. They were JOHN L. ELLIOTT, FENWICK T. NICHOLS, JOSEPH PACIFICI, and THOMAS R. FREEMAN.

Second District

L. M. BUCKNER spoke on "Water Safety" to the members of the Auxiliary to the Dougherty County Medical Society in April.

Third District

JOHN VAN DUYN, plastic surgeon of Columbus, addressed a meeting of medical technologists in April. "Medical Care for the Aged," was HARRY BRILL'S topic when he spoke to the Columbus Medical Assistants Association in May.

DR. and MRS. J. C. Serrato, JR. went to the University of Nuevo Leon in early May where Dr. Serrato delivered a paper on orthopedics.

HERSCHEL SMITH was honored at a surprise party in April. The party was given by the nurses of the Americus and Sumter County Hospital.

H. E. WEEMS, JR. and Dr. J. R. Arnold Announced the opening of their office in Perry.

Fourth District

R. J. MINCEY, JR. re-opened his medical practice in Thomaston on May 1.

T. J. BUSEY and WELLS RILEY attended the American Academy of General Practice in Miami in April.

ENOCH CALLAWAY of LaGrange spoke at Trinity Episcopal Church in Columbus during April. Also he spoke to the Americus Rotary Club on chemotherapy.

Fifth District

BRUCE LOGUE, Atlanta, recently addressed the Sixth District Medical Society at Dublin, Georgia. The title of his talk was "Clues of Inspection in the Patient with Cardiovascular Disease." He also addressed the Louisiana Heart Association at Shreveport, Louisiana about "Heart Disease in Pregnancy."

JOHN P. WILSON of Emory spoke to the volunteers in the 1961 Troup County Cancer education fund crusade.

A forum on athletic injuries sponsored by the Fulton County Medical Society and the Atlanta City Schools, had as their guest speaker FRED ALLMAN.

Sixth District

O. H. CHEEK retired after 41 years of service as Commissioner of Health for Laurens County.

The Macon Rotary Club heard JAMES E. BAUGH of Milledgeville speak on his impressions of the Russian people.

A couple of doctors from Sandersville, WILLIAM RAWLINGS and W. S. HELTON attended a short postgraduate course at the Medical College of Georgia in March.

THOMAS NED DAVIS of Irwinton attended the American Academy of General Practice 1961 Annual Scientific Assembly in Miami.

Seventh District

PAUL FITZPATRICK of Dalton was elected to membership in the American Diabetes Association in April.

Miami was the scene of the meeting of The American Academy of General Practice, which FLOYD MORGAN, Douglasville, attended.

Eighth District

JOE L. OWENS, JR. has returned to Brunswick and opened an office in the Professional Building.

A short postgraduate course at the Medical College of Georgia was attended by Nashville's W. A. DICKSON.

J. A. LEAPHART has returned to his medical practice in Jesup after an extended illness.

Ninth District

GRADY N. COKER was honored by the local civic clubs of Canton in April for his life time of service in medicine in that area.

J. J. ARRENDALE has been appointed as the doctor at the State Prison at Reidsville.

The State Welfare Department honored J. C. DOVER at a reception and gave him a citation for his devotion to his work in Rabun County.

Tenth District

W. J. WILLIAMS has announced the change of location of his office to 1423 Gwinnett St. in Augusta.

PHILIP A. MULHERIN, H. W. CLECKLEY, and C. H. THIPGEN were members of a panel sponsored by the Augusta-Richmond County Public Library. The topic of discussion was mental health.

A. B. CHANDLER had a paper presented in Chicago in April. The occasion was the scientific sessions of the International Academy of Pathology and the American Association of Pathologists and Bacteriologists.

WILLIAM E. LAUPUS of Augusta, recently was elected a member of the Section of Diseases of the Chest of the American Academy of Pediatrics.

The following doctors were appointed in April to examine Augusta's city employees: WILLIAM J. WILLIAMS, HARRY D. PINSON, M. H. WYLIE, W. EUGENE MATTHEWS, WILLIAM FULLER, W. W. BATTEY, ALFRED M. BATTEY, JR., HENRY W. BAILEY, PARK JEANS, LOUIS MANGANIELLO, and POMEROY NICHOLS.

Augusta's Walton Way Temple Sisterhood honored JOHN R. FAIR in April, at one of their meetings.

MASON H. SHEPHERD, Augusta, moved his office in April to 1413 Gwinnett Street.

EXECUTIVE COMMITTEE OF COUNCIL

THE APRIL MEETING of the MAG Executive Committee of Council was called to order by Chairman Milford B. Hatcher at 8:10 P.M., April 22, 1961 at Dr. Hatcher's home in Macon, Georgia.

The members of the Committee present were: Milford B. Hatcher, Macon, President and Chairman; Fred H. Simonton, Chickamauga, President-Elect; J. G. McDaniel, Atlanta, Chairman of Council; John T. Mauldin, Atlanta, Secretary; Luther H. Wolff, Columbus, Past President, and Virgil B. Williams, Griffin, Chairman of Finance. Also present were George R. Dillinger, Thomasville, Chairman of Committee Reorganization Committee; Linton Bishop, Atlanta, Co-Chairman of Local Arrangements Committee for MAG Annual Session, and Mr. Richard Nelson, AMA Field Representative. MAG Staff present were: Mr. Milton D. Krueger, Executive Secretary; Mr. James M. Moffett, Assistant Executive Secretary, and Mrs. Catherine Wooten, Executive Assistant.

Mr. Krueger read the minutes of the March Executive Committee meeting. There being no corrections, on motion duly made and seconded, the minutes were approved as read.

MAG Annual Session Publicity Mailing Recommendation

Linton Bishop asked for Executive Committee approval of a "flyer" to be sent out from MAG urging everyone to attend the Annual Session. It is estimated that \$125.00 to \$150.00 would be involved in printing and mailing this flyer. On motion (Wolff-McDaniel) it was voted to instruct the Annual Session Committee to mail a flyer to the MAG membership.

1961 Committee Appointments

(Executive Committee of Council made committee appointments where required. However, the Bylaws changes approved by the 1961 House of Delegates called for the reorganization of the committee structure of the Association. This necessitates a reconsideration of committee appointments to fit the revised MAG committee and board structure.)

Appointments to Board of Examiners of Practical Nurses

Executive Committee appointed the following: Albert L. Morris, Fairburn and Frank M. Houser, Macon, with instructions to Secretary Mauldin to notify Mr. Clifton, Joint Secretary, State Examining Boards, of these appointments.

Request for MAG Approval for Glaucoma Screening Project

Dr. McDaniel read a request from Mason Baird regarding a Glaucoma Screening Project by the Georgia Society of the

National Society for the Prevention of Blindness. He asked for sanction of the MAG for the project. On motion duly made and seconded it was voted to approve the project and to so notify Dr. Baird.

Treasurer's Report

In the absence of Dr. Arp a copy of this report was given Executive Committee and accepted for information. Secretary Mauldin reported that \$10,000 has been deposited in three savings accounts to draw four per cent interest.

Vocational Rehabilitation Conference

Secretary Mauldin read a letter from the Vocational Education Division of the State Department of Education asking for appointment of a representative from MAG to serve on a Planning Committee representing the health agencies to plan a series of Conferences in October 1961 regarding practical nurses. On motion duly made and seconded, Rafe Banks was recommended for this position.

Medic-Alert Foundation

Secretary Mauldin read a letter from the California Medical Association regarding this foundation. On motion (McDaniel-Williams) it was voted that this be referred to the Public Relations Committee to work out some program and make recommendations.

Georgia Veterinarian Association Request to Join Interprofessional Council

After discussion by Mr. Krueger, on motion (Wolff-Mauldin) it was voted that this be favorably referred to the MAG representative on the Interprofessional Council be brought up before the Interprofessional Council for decision.

AMEF Presentation

Mr. Krueger reported that checks had been received from AMEF to be given to the medical schools. Dr. Hatcher recommended that these be presented at the Annual Session President's Banquet. On motion duly made and seconded it was voted to present these checks at the President's Banquet and to have the Executive Secretary write a letter to the Dean of each school inviting him to be present for the presentation.

AMA Legislative Keyman

Mr. Krueger read a copy of a letter from AMA addressed to J. Frank Walker, informing him of his appointment to this position. This was accepted for information.

Committee on Committee Reorganization Report

George Dillinger gave the report for Executive Committee consideration. Each recommendation was read and discussed. Realizing that further work would have to be done, it was recommended that a meeting of the Constitution and Bylaws Committee, MAG attorney, President Hatcher, and Secretary Mauldin be held May 7, 1961 at 9:00 A.M., at MAG Headquarters for the purpose of studying this report and approving it if possible. A copy of the report to be sent to above persons for study prior to meeting.

Miscellaneous Correspondence

(1) *Implementation of Kerr-Mills Bill*: A copy of a letter from Mr. Sheffield Owen to Governor Vandiver was read by Dr. Mauldin recommending implementation of the Bill at an early date.

(2) *Frost and Frost*: Mr. Krueger read several letters regarding this company which publishes credit information. On motion duly made and seconded it was voted to have Mr. Krueger write the company that it was not MAG policy to endorse such services.

(3) *Family Plan Company*: On motion duly made and seconded it was voted to write this company that MAG cannot allow use of its name for publicity purposes.

(4) *Georgia Podiatry Association*: Deferred.

(5) *Physical Therapy Bill*: Deferred.

New Business

(1) Certain professional conduct problems were discussed.

(2) Macon meeting, April 23, procedure was discussed.

(3) The date and site of the May Executive Committee meeting was postponed, to be designated by the President later.

There being no further business the meeting was adjourned at 1:30 A.M., April 23.

NEW MEDICARE MANUAL

(Light Blue Cover)

Available Now Upon Request

Up to Date

**Procedure Maximum
Allowances**

**Write: MAG Medicare Department
938 Peachtree Street, N.E.
Atlanta 9, Georgia
TRinity 5-6303**

USE OF MATERNITY SERVICES INCREASING

THE USE OF HEALTH services for maternity care in this country increased significantly in a recent five-year period, Health Information Foundation reported recently.

In the March issue of *Progress in Health Services*, its monthly statistical bulletin, the Foundation analyzed findings of a nationwide survey conducted jointly by H.I.F. and the National Opinion Research Center of the University of Chicago.

Members of 2,941 families, representing an area-probability sample of the civilian noninstitutional population of the U. S., were interviewed in 1958 on a variety of health matters, including the use of maternity services. Results of this survey were compared with those of a similar study made five years earlier.

In general, the study showed, women who had a live birth at some time during a 12-month period in 1957-58 sought medical care earlier in pregnancy and used more physicians' services than had expectant mothers five years earlier. In 1957-58 relatively more confinements were medically attended and took place in hospitals; however, the average length of hospital stay per confinement was shorter in the more recent period.

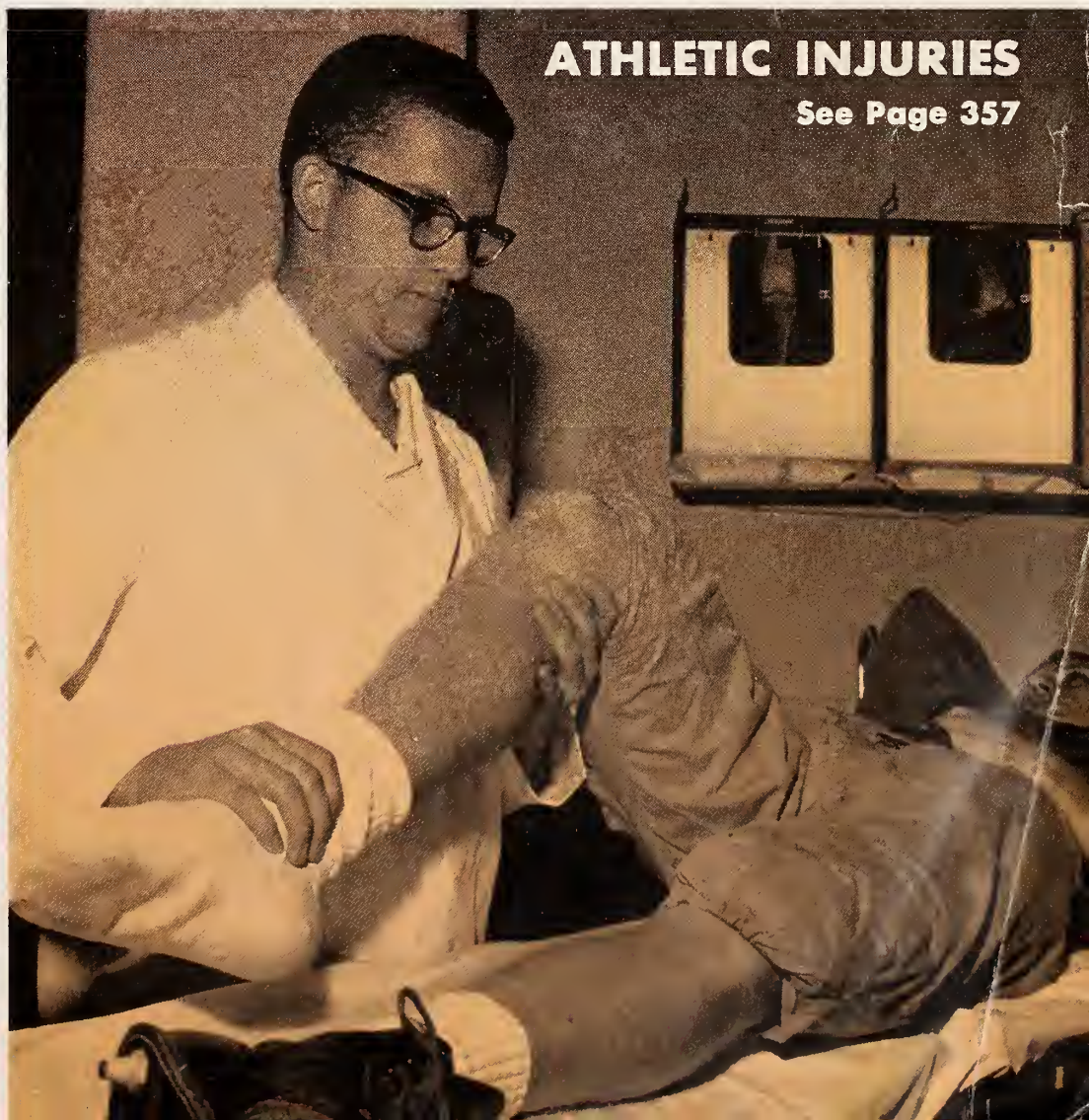
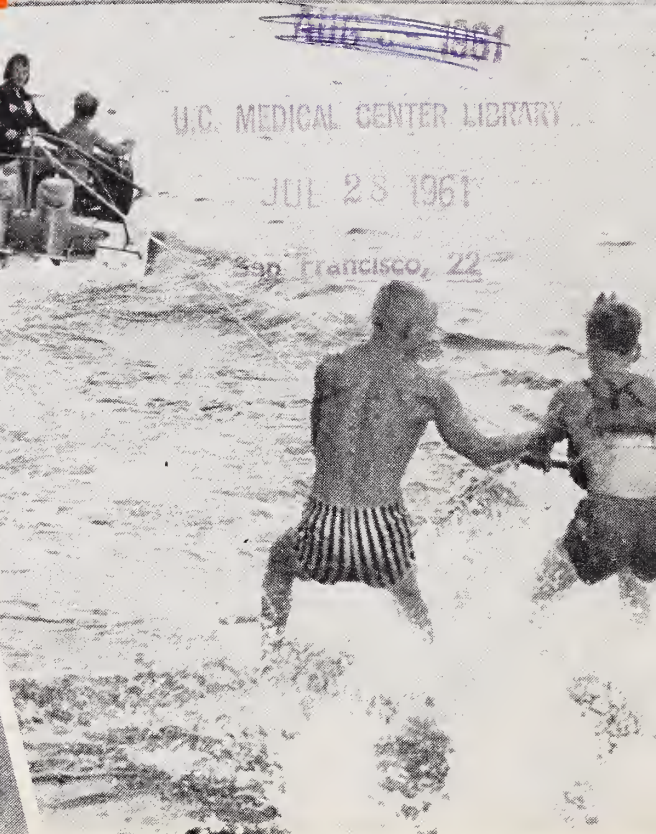
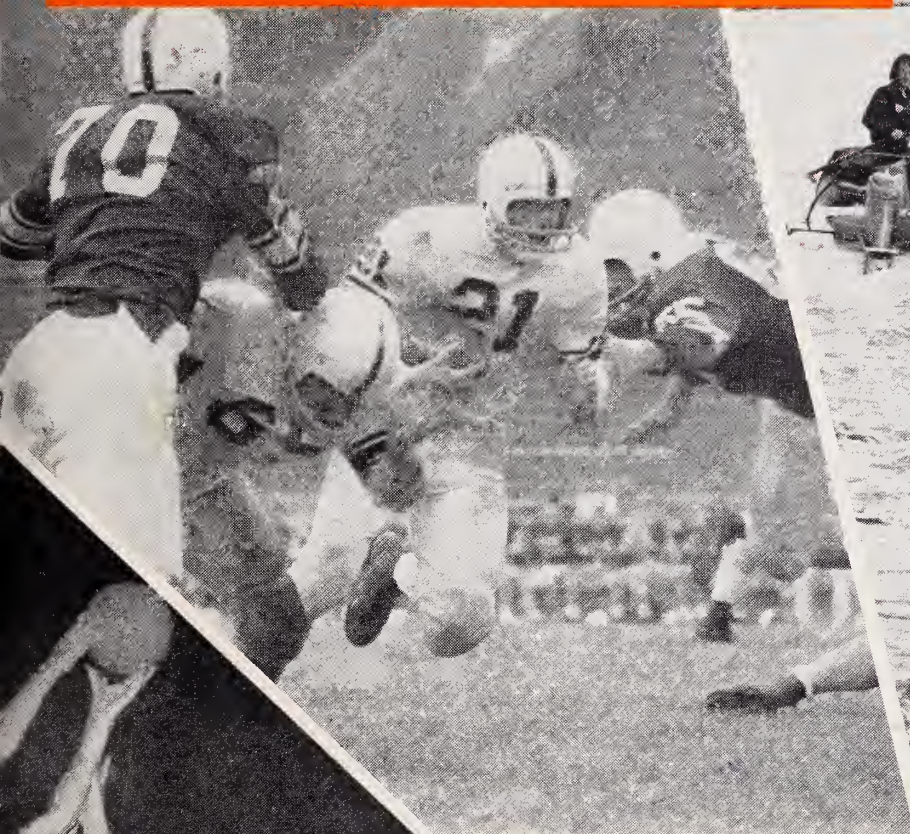
In 1957-58, the total private expenditures on maternity services in this country came to an estimated

\$1,150,000,000—an increase of more than 50 per cent in five years. This figure does not include the dollar value of *free* maternity services provided by private and governmental sources.

The average maternity patient in 1957-58 spent \$272 for all hospital, physicians' and similar services received, a rise of 41 per cent over the earlier figure. But the proportion of these costs covered by voluntary health insurance also increased in the five-year period.

In 1957-58 the amount of health insurance benefits covering maternity-care costs totaled \$436,000,000 for the country as a whole—almost double the 1952-53 figure. Benefits as a proportion of expenditures, increased, between the two surveys; in 1957-58, for example, families receiving maternity benefits had 58 per cent of their total maternity expenses covered by these benefits.

Almost 99 per cent of the live births reported for the 1957-58 survey were attended by a physician in a hospital. About 51 per cent of the maternity patients in 1957-58 had seen a physician during their first or second month of pregnancy, and 77 per cent of all obstetrical cases had seen a doctor by the end of the third month. The average patient had about 10 physician visits during her pregnancy.



ATHLETIC INJURIES

See Page 357



inside as well as outside the hospital...
staphylococci usually remain sensitive to

CHLOROMYCETIN

(chloramphenicol, Parke-Davis)

That the sensitivity patterns of "street" staphylococci differ widely from those of "hospital" staphylococci is a well-established clinical fact.¹⁻⁵ Although strains of staphylococci encountered in general practice have remained relatively sensitive to a number of antibiotics,⁶ the problem of antibiotic-resistant staphylococci appears to be a threat to all patients in hospitals today. It is encouraging to note, however, "...that a relatively small percentage of strains develop resistance to chloramphenicol, despite the consumption of large amounts of this antibiotic."⁷

In one hospital, for example, CHLOROMYCETIN "...was the only widely used antibiotic to which few of the strains were resistant."⁸ In another hospital, despite steadily increasing use of CHLOROMYCETIN since 1956, "...the percentage of chloramphenicol-resistant strains has actually been lower in subsequent years."

Elsewhere, insofar as hospital staphylococci are concerned, it appears that "...the problem of antibiotic resistance can be regarded as minimal for chloramphenicol."

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals[®] of 250 mg., in bottles of 16 and 100.

See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after short-term and with prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influenza, viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

JOURNAL OF THE MEDICAL ASSOCIATION

Georgia

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John McKenzie, Joe Jackson

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OUR RESPONSIBILITY IN THE PREVENTION AND TREATMENT OF ATHLETIC INJURIES

Fred L. Allman, Jr., M.D., *Atlanta*

The physician must play the lead role in this program.

RECENTLY AN ILLINOIS pediatrician writing on "Athletics and the Child" stated that competition is perhaps the most serious deterrent to development of a physically active population, and pointed out that disappointment is not often a motivating influence to a child. He went on further to add that whenever competitive team games are promoted, far more children will be left out than included.

To condemn competitive athletics on this basis is like doing away with colleges and graduate schools because everyone is not intelligent enough to gain entrance. Mr. Barnaby C. Keeney, President of Brown University, in *The Atlantic* recently stated that it is again becoming apparent that "firm standards are indispensable in judging the achievement of students, and students must be made aware that these standards are fair and desirable. Firm standards require that a distinction be made between success and failure, between excellence and mediocrity. Pretense that success has been achieved when it has not must be eliminated. A student must learn to accept failure as well as success and learn to make a clear distinction between the two." The student, therefore, must compete.

The inborn desire to compete is certainly present in most children and remains so in many throughout life. If these children are not given the proper leadership and training, then they will seek avenues of their own and wind up on vacant lots playing without leadership or even worse, by competing in neighborhood gang warfare.

While I cannot without question prove that competitive athletics build character, I can without

question state that it requires character to compete in athletics.

There is, however, one valid criticism to competitive athletics, and that is injuries, both temporary and permanent. For there is no question on this point—athletes do get injured. In the nation last year there were 12 deaths as the result of football injuries. (This was the lowest level since 1955.) Of these, ten were of high school age (seven in high school athletics and three in sandlot), one in college and one in professional ranks. Seventy-two per cent of all football fatalities come from head or spine injuries. Of the seven deaths in high school boys, 42.8 per cent occurred as a result of tackling or being tackled.

In the 23 Atlanta high schools last fall there were, among the 2,500 senior high participants and 700 eighth graders, 604 injuries serious enough to require the services of a physician. There were roughly 100 injuries to the head and neck, 100 to the upper extremity exclusive of the hand, and 100 to the hand. There were 50 injuries to the knee, 100 to the ankle and foot and 65 to the back. There were 54 fractures. The average number of injuries per school was 26.2 per cent.

Fortunately, as of this time, I do not know of any of these injuries that will constitute a serious disability in the future. Since the conclusion of football, however, we have had a very serious injury in a high school boy who sustained a dislocated neck which resulted initially in quadriplegia. I am happy to report that today, less than three months following injury, he has shown remarkable recovery, and in fact we expect near complete recovery in the future. This case, our most serious injury, occurred not in a football player, but in a pole-vaulter,

OUR RESPONSIBILITY / Allman

a non-contact sport. This injury can be attributed to faulty equipment, as it occurred when the vaulting pole broke.

Our task then, if we are to defend competitive athletics, is to focus our attention on the only valid criticism to competitive athletics—injuries.

Lord Bryce once stated that medicine was the only profession that labors incessantly to destroy the reason for its own existence, and while this is true, the results of the profession in many fields has not been too successful in prevention of illness or accidents. I feel that in the prevention of athletic injuries, however, we have a problem which will show a dramatic response to preventive measures—if properly instituted. Just as important as prevention of injury is prevention of re-injury.

Prevention of athletic injuries requires many measures, all of which are important. These include proper leadership both from administrator and coach. The coach should be well trained and have the respect of each athlete. He must be capable and fair and must have the ability to instill within each boy the desire to win, and yet to teach that victory sometimes can be gained even in defeat. He and the administrator must provide proper equipment and playing conditions as well as the knowledge of how to play and the condition of being physically fit to play. It is the responsibility of the administrator, the coach, the player and the parent, as well as the physician, to see that athletics does not lose its proper perspective, and that adequate emphasis should at all times be placed on mental as well as physical development. The greatest responsibility of all, however, is with the physician, for he is the only person capable of telling when a boy is fit or unfit for the particular sport which the individual chooses, and the one who should take the lead in any program of prevention of injury.

What are the responsibilities of a physician in prevention and treatment of athletic injuries? It is the responsibility of the physician to provide pre-seasonal histories and physical examinations, and in this manner to eliminate those who are physically incapable of physical exertion. (To these individuals some other form of activity compatible with their physical capabilities should be made available.) He should see to it that records of injuries and illnesses are kept and reviewed. He should accept the responsibility of referral when he is confronted with a problem which he is not capable of treating. He should be available to advise with school authorities and coaches on medical costs and financing as well as suitable insurance programs. He should check dressing rooms pre-game, at half-time and after the

game for any injuries, illnesses or strange behavior. He should be available during practice hours and should know the players. He should be on the bench and be "in the know" on the mechanism and treatment of athletic injuries, and he should make decisions regarding playability. This is not a decision for coach, parent or player. It is one that should be made by the physician without pressure or influence from outside sources.

There are at the present time in this country some 18,000 physicians engaged in the care of school athletes—most of them without pay. A portion of most of the larger medical meetings is devoted to some phase of the prevention of athletic injuries. Medical committees and other organizations have been formed to work with school officials in this program.

Treatment of athletes differs very little from the treatment of any other patient. There are six principles that have been listed by Dr. Don H. O'Donoghue as being foremost in the treatment of athletic injuries. These are:

1. The goal must be complete recovery.
2. It is important to avoid mere expediency.
3. The best treatment must be selected, rather than the most convenient.
4. Treatment must be definitive.
5. Treatment must be prompt.
6. The physician must believe in competitive athletics, for if the physician does not believe in competitive athletics, he will not have the complete interest of his patient, and the patient will not have faith in the physician. The athlete should be allowed to return to athletics as soon as his recovery is complete. Once this feeling becomes known to athletes and coaches they will no longer be hesitant about consulting the physician when injury occurs.

As a result of the analysis of our injury records for the past football season, the committee for the Prevention of Athletic Injuries of the Fulton County Medical Society has made the following recommendations to the Atlanta schools, and has been assured that they will be carried out at the earliest possible date, some of them by spring practice, others by next fall. These recommendations are:

1. No child shall be allowed to participate in any form of athletic event until he or she has been actively immunized for tetanus.
2. Low top football shoes should be eliminated and all players returned to high top shoes.
3. Every ankle should be either taped or strapped before each practice and game. It is reported that the incidence of ankle injuries is ten times higher in the non-supported ankle than in the supported ankle.

4. No athlete should be allowed to return to a game following a period of unconsciousness, regardless of how brief a period the unconsciousness might have been.

5. No athlete should be allowed to participate who is unable to operate at full speed and without a limp.

6. Mouth pieces should be made available to each player and its use made mandatory.

7. More emphasis is to be placed on pre-seasonal and seasonal conditioning, with more time and consideration being given to the thigh muscles and weight lifting.

8. A sponge rubber protector for the back of the hand should be utilized during practice.

9. A qualified physician must be present and on the bench at each game.

We feel that by adoption of these recommendations we can show a marked reduction in the number of athletic injuries in the Atlanta area in the future, and we further feel that in reducing the number of injuries, and removing some of the hazards associated with competitive athletics, that we can justify competitive athletics and in so doing focus the attention of our youth on something besides fast automobiles, television, crime movies, comic books, gang warfare and even poorly organized sandlot activities.

In Summary

I feel that there is a definite need in this country for competitive athletics, just as there is need for competition in the classroom and in business, if we are going to remain a strong nation.

Further, I feel that by adopting the previously mentioned recommendations, we can reduce the number of athletic injuries and thus, in part at least, can give an answer to the only valid criticism of competitive athletics—namely injury.

The physician must play the lead role in this program, for he only is capable of deciding playability—if we fail, then the lead will be taken by trainers, physical therapists or even chiropractors.

The challenge has been made. I hope we as physicians will answer this challenge.

340 Boulevard, N.E.

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Presented at the 107th Annual Session of the Medical Association of Georgia, May 7, 1961, Atlanta, Georgia.

AWARDS OF HONOR PRESENTED AT EMORY MEDICAL MEETING



Pictured above are (l) C. B. Upshaw and (r) J. D. Martin, Jr., both of Atlanta. They were presented with Awards of Honor by the Medical Alumni Association of Emory on April 3. The awards were



given in "Recognition of Service to the Field of Medicine and to Emory University and the School of Medicine."

BASEBALL FINGERS

Early treatment is essential if a good end result is anticipated.

Augustin S. Carswell, M.D., Augusta

IN DISCUSSING BASEBALL or mallet fingers with a group like this I feel like the little boy who sat on the cake of ice, my tale is told. If you will recall, Dr. Darius Flinchum gave a very good presentation of this at the meeting in December '59, however, there are several points that I would like to re-emphasize. If you will bear with me for the sake of anyone here who is not familiar with the mallet or baseball finger. It is an injury to the distal phalanx that one sees either from a laceration of the thin extensor tendon over the distal IP joint which severed the tendon or a subcutaneous rupture caused by a blunt object falling across the joint or as the term implies, a baseball might hit the end of the finger causing forceful flexion which may avulse the extensor mechanism from the proximal end of the distal phalanx. The unopposed flexor tendon draws the distal phalanx into a flexed position and hence, the typical drooping at the distal IP joint or the inability to extend the distal IP joint. As in most cases when you have many suggested methods of treatment, you can rest assured that no one particular method is satisfactory in all cases.

All suspected mallet fingers should be thoroughly examined and x-rayed. This should be done early; As the results of treatment in the early diagnosed are much better than those later on. Several different methods of treatment have been suggested.

1. Casting.
2. Splinting, padded aluminum splints.
3. Internal fixation with a short pin.
4. Internal fixation with a long pin.
5. Tendon repair with pullout wire suture through the fingernail.

In the fresh injuries, probably flexion of the proximal IP joint with the distal IP joint extended to approximately 180 degrees and skin tight plaster is possibly the best choice. One point that I would like to bring out here, in previous discussions of this it

was suggested that you flex the proximal IP joint and extend the distal IP joint. It is requested that each of you hold your own finger, flexing the proximal IP joint and to hyper-extend the distal IP joint and note the blanching of the skin over the distal IP joint. The more you hyper-extend the distal IP joint, the more ischemic the skin becomes, however, if you will note you are able to extend the distal IP joint to approximately 180 degrees without any color change noted in the skin. Many of the complications in treating mallet fingers was the slough over the distal IP joint. Several people have thought this was due to pressure that was applied with the application of the cast or whatever material that you use for immobilization. I believe that this is due to ischemia in the hyper-extended position rather than pressure from the material used to immobilize. It is further suggested that in treating this, you ask the patient to hold his finger using the opposite thumbnail under his finger nail to flex the proximal IP joint but to extend the distal IP joint to only 180 degrees being careful not to markedly hyper-extend it. And with the injured finger in this position to apply a skin tight cast which should be worn approximately three weeks. It is suggested that the patient avoid heavy muscular work during healing as the cast will become loose and the deformity will increase. In those that are recognized later you may want to accept the deformity. The treatment of those with avulsion fractures should be opened up by an incision over the back of the joint, the fractured edges roughened up with a small dental chisel, staying away from the articulating surface as much as possible. For internal fixation you may use either the short or long pin, with a short pin it is suggested that you use Collodium to fix the proximal IP joint in flexion and the long pin (Pratt method). This is the one that I prefer for the open reduction. Pullout wires have been used for internal fixation in those later recognized, the

fixation usually takes from four to six weeks; even surgery does not correct all of these completely. Sometimes in those recognized late with minimal disability, it is better left alone. One other method of treatment of this is in the markedly comminuted to fuse the IP joint.

Presentation of Cases

We have not had a great number of cases, as a matter of fact about seven or eight which is less than ten and is not a series large enough to let us form an opinion. These are varied. Approximately four of them which is about 50 per cent, were fresh or were recognized early and treated early with much better results. Approximately four of them about 50 per cent were seen later, either having been treated by someone else or having received no treatment at this time on the fresh case. One does very well casting these by flexing the proximal IP joint and hyper-extending the distal IP joint. There was a case of a laceration over the dorsal aspect of the distal IP joint which was an industrial case and at the time of the initial examination it was felt that the laceration did not include the extensor tendon. Approximately one week after the accident, the patient caught his finger between a bolt and the side of a trailer and afterwards had about a 30 degree drooping in the distal IP joint. There was no fracture noted in this injury. After about three months the tendon appeared to have healed, the patient tended to hyper-extend the opposite finger on extension and was only able to extend the injured finger to 180 degrees which we felt was better than surgery could offer.

In another case the x-ray showed an avulsion of a small portion of the distal cortex of the proximal end of the distal phalanx of the fifth finger. There was about 45 degrees drooping at the distal IP joint. This patient was a school teacher and was very insistent that something be done to correct this. An open reduction was done under a tourniquet. Through an incision over the distal IP joint the avulsed cortical bone was removed from the tendon with a small dental chisel, the area of attachment was freshened up. The tendon was re-attached with some pullout wires through a small drill hole and the finger was fixed with the distal IP joint hyper-extended and the proximal IP joint flexed with a Kirschner

Wire after the method of Pratt. The wound was a little slow to heal. Sutures removed in ten days, pull-out wires removed at the end of three weeks, and the Kirschner Wire at the end of five weeks. Cosmetically, there were good results. There was a full range of motion in the proximal IP joint with about 60 degrees in the distal IP joint. The patient was able to extend to about 175 degrees. In the other fingers that were seen, in one case surgery was recommended but declined and in the other a cast was tried for three weeks with some improvement but there was still approximately a 35 degree drooping to the distal IP joint.

Types of Treatment

In those recognized and treated early, unless there is avulsion of the bone, it is suggested that a skin tight cast be applied with the proximal IP joint flexed and the distal IP joint extended until blanching of the skin develops and that a good lateral dental film be made to be sure that there is no avulsion of bone. The patient is requested to flex the proximal IP joint and by holding the nail with the opposite thumbnail to extend the distal IP joint just short of blanching of skin on the distal aspect, this is usually between 180 and 185 degrees and this is wrapped with a skin tight plaster which is worn approximately three weeks. In those cases with avulsion fractures in which there is no subluxation of the distal IP joint on extension, it is suggested that they be treated likewise. In those with subluxation, probably an open reduction with pullout wire fixation of the avulsed fracture early is probably better. In those recognized later with no deformity the Pratt method appeals to us and has proved most satisfactory in our hands. In those with marked comminution, probably a fusion of the distal IP joint is the treatment of choice.

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Presented at the 107th Annual Session of the Medical Association of Georgia, May 7, 1961, Atlanta, Georgia.

WIN A PRIZE

SOUTHEASTERN SURGICAL CONGRESS announces the prize scientific paper award contest eligible to residents of approved hospitals in the southeastern states for the best scientific papers.

Papers are due at the congress office at 340 Boulevard, N.E., Atlanta 12, Georgia, before December 1, 1961. The prize for the first place winner is an all-expense paid trip to the meeting at Louisville, Kentucky, March 5, 6, 7, 8, 1962, plus a cash award.

LIGAMENTOUS INJURIES TO THE KNEE*

Jack C. Hughston, M.D., *Columbus*

Injuries to the major ligaments of the knee constitutes the most serious acute knee injury in the athlete. Early (immediate) diagnosis is essential for obtaining the best results. The treatment must be early as well as appropriate to the degree of tear. Unequivocally, the complete ligament ruptures necessitate surgical reapposition within the first 24 to 48 hours. In athletes, the goal of any treatment is a return to 100 per cent of normal function.

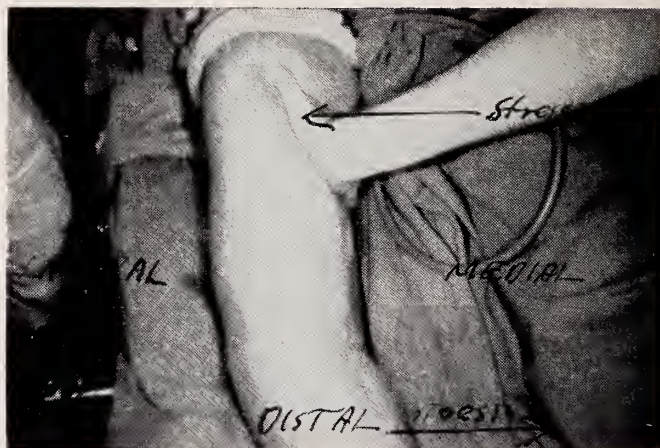
The physician can best diagnose a rupture of the medial or lateral collateral ligament of the knee joint when he is present on the side lines, observes the injury and the mechanism involved, and examines the knee at that moment. The athlete with such a rupture can rarely stand up and walk off the field. Frequently the malalignment of the lower extremity at the knee is evident while the player is still recumbent upon the grass.

The definitive examination should be unhurried and should take place on the side lines or in the dressing room. The heavy protective equipment must be removed sufficiently to allow access to the injured part.

Recognizing the complete rupture immediately following the injury is no problem. The whole knee seems to fall apart in ones hands as the examiner applies stress from one side, and then the other. However, 15 minutes later the hamstrings and quadriceps muscle groups may have developed enough protective spasm to splint the ligamentous instability so that the looseness of the joint cannot be demonstrated. When the index of suspicion is quite high and muscle spasm is splinting the knee, examination under anesthesia is indicated. The orthopedic surgeon can be prepared to immediately

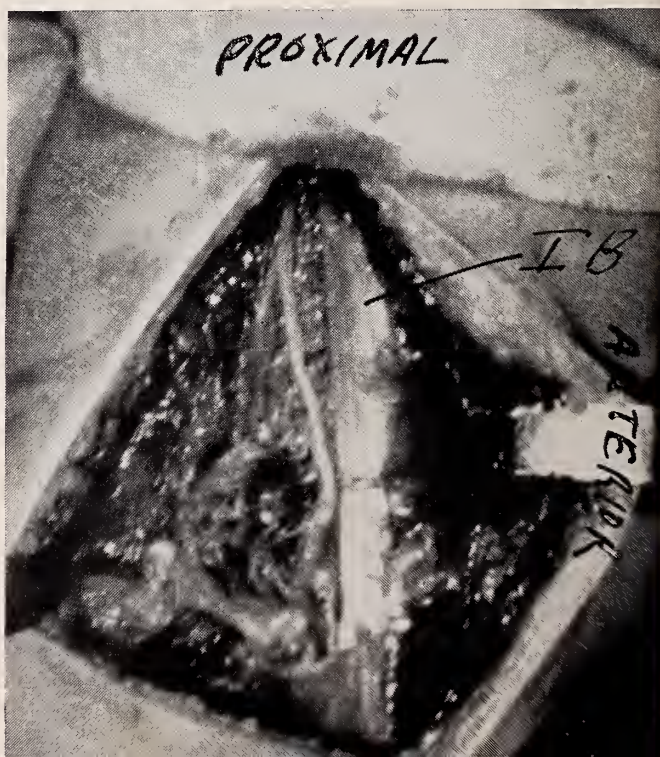
(Continued on page 352)

CASE A.T.



A.T. 'A' demonstrates preoperative examination of a knee. This player's lateral instability was evident to his trainer and his team physician at the time of injury. A few hours later muscle spasm prevented demonstration of the instability. This photograph clearly shows the extreme instability of the lateral compartment when stress was applied with the patient anesthetized.

A.T. 'B' As soon as the skin incision was made over the total aspect of the knee the iliotibial band (IB) was evident and its posterior half was shredded like spaghetti. The hemorrhage in the soft tissues was diffuse.

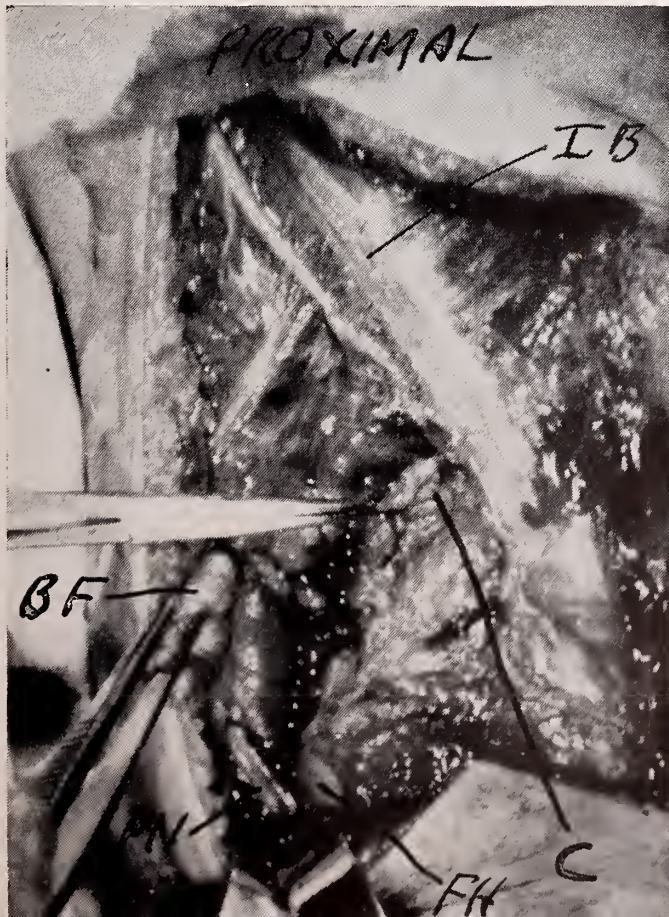


* Knee injuries to the menisci and patella were also discussed. The technique of examination of a knee was demonstrated.



A.T. 'C' The hemostat is retracting the capsule (C) inferiorly; the capsule was torn loose from the lateral femoral condyle (FC). The top of the tibia and the lateral meniscus (LM) is exposed. The fibula head (FH) is bare, the biceps femoris tendon having been avulsed.

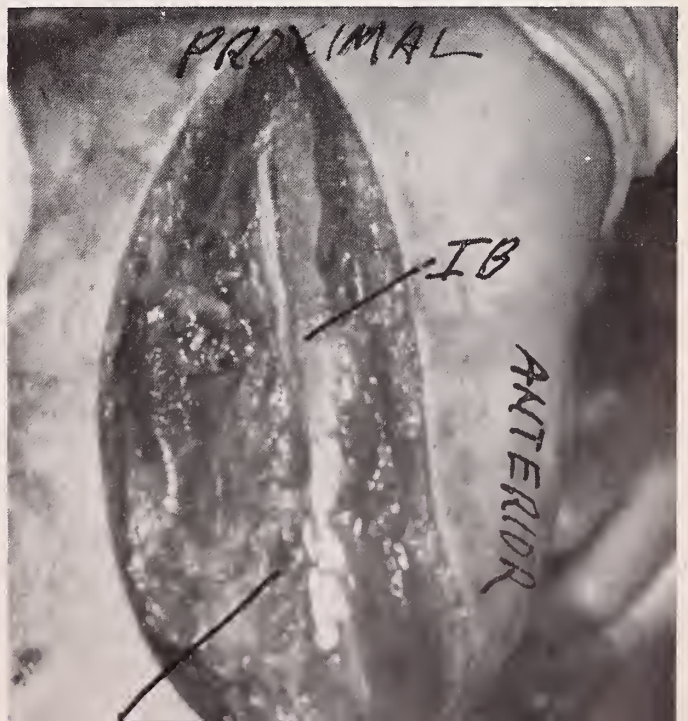
A.T. 'E' The capsule (C) is replaced in its proper location. The avulsed tendon of the biceps femoris (BF) is held in the forceps. The traumatically exposed peroneal nerve (PN) is evident posterior to the fibula head (FH). This player did not have a stretch paralysis of the nerve.



A.T. 'D' When stress is placed on the joint to open it laterally, the same as was done preoperatively, the structures are as follows:
J — open joint

FC — femoral condyle and its articular surface
LM — lateral meniscus
C — capsule reflected inferiorly by the hemostat
P — the avulsed and macerated popliteus muscle
FH — fibula head.

A.T. 'F' All structures have been reapproximated and sutured in their appropriate places prior to skin closure. The joint was stable to stress. Postoperative care consisted of a plaster immobilization in 25 degrees of flexion for seven weeks. Progressive resistance exercises were carried out in the cast, as well as after discontinuance of immobilization. Weight bearing without crutches was not begun until the player had regained moderate muscle volume and muscle tone, as well as regaining a fair degree of motion. Playing was not resumed until full motion and full muscle power was regained. The following season this halfback had regained his preoperative quality of performance on his essentially normal knee.



INJURIES TO KNEE / Hughston

follow this examination with surgery; this will save a repeated anesthetic in the positive cases. Surgical repair is followed by six to eight weeks plaster immobilization.

If the tear is partial, rather than complete, conservative treatment is preferable with a plaster cylinder immobilization for six to eight weeks, with progressive muscle development during and after the immobilization.

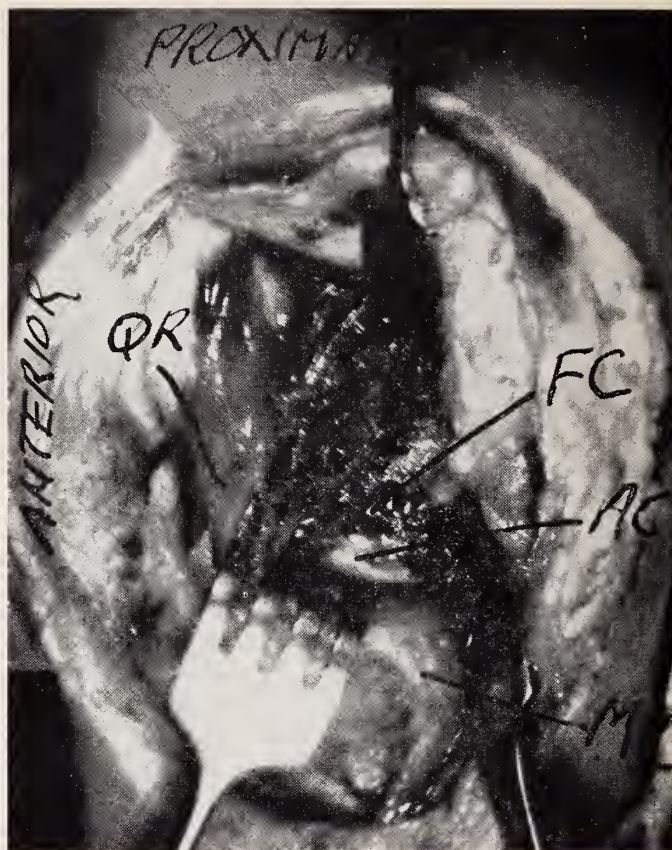
The medical components of the knee are more frequently injured than the lateral. The most usual cause is the clipping type injury. Unfortunately, the injury does not often consist of merely the ligament tear. Frequently the anterior and posterior cruciate ligaments are also torn. The meniscus is often torn. The retinaculum and joint capsule are torn. Sometimes the gastrocnemius belly, the popliteus muscle, or the biceps femoris are torn. Surgical reconstruction necessitates repair of all torn structures and removal of the meniscus when it is torn.

* Case R.J. and Case A.T. are from "The Athlete and His Knees" presented at the Southern Medical Association, 1959, by Doctors Hughston, Whatley, and Dodelin, Columbus, Georgia.

CASE R.J.



R.J. 'A' This player received a clipping type injury to his knee with a resultant rupture of the medial compartment. This depicts the considerable and diffuse hemorrhage into the subcutaneous tissues over the medial compartment.



R.J. 'B' Beneath the subcutaneous tissues is seen the medial femoral condyle (FC) from which the greater portion of the medial collateral ligament (MC) is torn, the loose end of the ligament lying in the joint over the top of the medial meniscus. The meniscus was not torn. (AC) Articular cartilage of the femoral condyle. (QR) Quadriceps retinaculum is partially intact anteriorly.

R.J. 'C' The loose end of the medial collateral (MC) ligament has been pulled out of the joint and is laid back on its tibial portion. A small remnant of the medial collateral ligament (MCL) is still attached to the femoral condyle. The raw surface (RS) is evident where the loose end of the medial collateral ligament was originally attached. (C) is the area of avulsion of the capsule. The retractors (R) demonstrate the posterior extent of the rupture.





Postoperatively, the muscle redevelopment is most important. The average recovery period should allow the player to rejoin his teammates in practice four to six months after injury.

A typical tear of the medial compartment is demonstrated by Case R.J. with a description of the findings. The lateral compartment rupture is demonstrated by Case A.T.

CONCLUSION

Ligament tears must be diagnosed immediately and treated early. In this respect they are more serious than fractures of the bone. The x-ray helps diagnose the fracture whereas the ligament tear is not discernible. The fracture is treated; the ligament too often receives watchful expectancy carried to hopeful procrastination. A non-union of a fractured bone can be bone grafted and frequently become as good as new. A ligament cannot be secondarily repaired, grafted, or reconstructed with any comparable degree or frequency of good results. Thus, ligament ruptures must be diagnosed and treated early for the perfect results necessary for future athletic success.

OUR TESTIMONY TO BE PRESENTED

THE MEDICAL ASSOCIATION of Georgia currently plans to present testimony in opposition to H.R. 4222, the King bill, before the Ways and Means Committee of the House of Representatives in Washington.

At the June meeting of Council approval was given to a plan to draft and present oral arguments to the Ways and Means Committee outlining the position of MAG regarding this legislative proposal.

This decision of Council followed closely the announcement by Congressman Wilbur Mills, Committee Chairman, that public hearings on H.R. 4222 would be held when his Committee concludes its deliberations on tax legislation. It is contemplated that this will be some time during mid or late July.

In taking this action, the Council gave expression to a resolution adopted at the 1961 Annual Session by the House of Delegates which called for "opposition to the King bill."

The extent of misinformation which has been released by the proponents of this bill is so great that only protracted hearings by the Ways and Means Committee could clear up the confusion attending this legislation.

Up to now many of the backers of this bill have relied on emotionalism and rigged statistics to create

what they felt to be the proper legislative atmosphere in which a bill of this type could be enacted.

They have deliberately sought to create the impression that the great majority of our people, age 65 and over, are destitute or nearly so. To support this false conclusion they have paraded a battery of loaded statistics calculated to prove their point. Through public and private media for the dissemination of news they have attained a measure of success. However, their moment of truth will come at the Committee hearings in Washington.

In the cool, calm atmosphere of Congressional hearings, MAG will attempt to show: that historically, the medical profession in Georgia has always had a genuine concern for the problems of our aging citizens; that the problem of rendering medical assistance to our senior citizens can best be handled when administered on the basis of need rather than mere blanket coverage of all persons over age 65; and that this bill is fiscally irresponsible and philosophically inconsistent with good order and the fundamental American belief in the dignity and self reliance of the individual.

A formal request to be heard on this bill has been made. It is contemplated that these hearings will run a full two weeks.

ISCHIAL APOPHYSITIS WITH CASE REPORTS

B. Lester Harbin, M.D.; James M. Kelley, M.D., *Rome*; Floyd Bivens, M.D., *Augusta*

Common activities implicated are football, basketball, track and acrobatic dancing.

ALTHOUGH ISCHIAL APOPHYSITIS, sometimes called "avulsion of the ischial tuberosity," has been known as an entity since 1912 only about two dozen cases have been reported in the literature. We wish to add two further cases and at the same time encourage x-ray investigation of future cases in hopes that more may be learned about the prevention and treatment of this disorder.

The apophysis of the ischium, according to Goff, is the developmental remnant of a former true bone which in other species of animal was used for attachment of large muscles employed in the manipulation of the reptilian tail. The ischial apophysis apparently does not have a definite time for full maturation and ossification and again Goff feels that disturbances in this apophysis should be classified as false osteochondroses dependent upon trauma as an exciting agent.¹

A review of the anatomy will reveal that the ischial apophysis is not only the site of origin of the hamstrings, but also the medial aspect of the apophysis provides origin for the adductor magnus.

Rogge and Romano have pointed out the similar history which is obtained in most instances of apophysitis of the ischium.² The patient is usually athletic and under 25 and has had recent strenuous muscular activity. Common sports implicated are football, basketball, track and acrobatic dancing. The complaint is sudden pain in the buttock following exertion particularly following straight leg raising with a maximum of effort. Physical examination usually reveals tenderness over the ischial tuberosity and x-rays will reveal the typical findings of apophysitis. Failure to obtain x-rays may lead one to more bizarre diagnoses but with adequate rest the patient

usually recovers completely without definitive treatment.

X-ray changes are not dissimilar to those associated with sarcoma for the cortex may be broken or even disappear over areas of lysis and in the unilateral cases a desire to biopsy the lesion may be overwhelming. This has been done and the pathology found is compatible with the usual apophysitis.

Martin and Pipkin have divided disorders of the ischial tuberosity into three categories.³ Their first category, apophysiolyis, has been covered in the above discussion. Their second category, somewhat more serious as an injury, is avulsion of the apophysis of the ischium or avulsion fractures of the ischium in the mature adult. Such cases are diagnosed easily by x-ray because of the amount of separation between the body of the ischium and the avulsed fragment. In many instances, it is reported, there is spontaneous reduction and uncomplicated healing of this fragment with no sequelae. However, if fibrous union should occur or if marked callous formation should be the result of incomplete reduction the patient finds it uncomfortable and sometimes awkward to sit upon the enlarged tuber. There are a growing number of authors who advocate open reduction and fixation with screws of this fragment. Certainly this should be considered in the case with marked separation.

The third category described by Martin and Pipkin is a result of the avulsion fracture and these old united avulsions, if symptomatic, might require surgical intervention with resection of a portion of the large and uncomfortable bone and possible internal fixation.

The treatment of the three basic types of dis-

orders of the ischial tuberosity deserves brief review. The treatment for apophysiylolysis consists of bed rest and symptomatic care. Avoiding strenuous contact sports for a period of six weeks to three months is advisable. The more severe condition of avulsion of the ischial apophysis should be treated with open reduction and probably internal fixation. The results of failure to treat such an avulsion may require more extensive treatment such as excision of the fragment or excision of the enlarged portion of the ischium.

Two young High School students have been seen within the past two years by the authors both with a history of a dull aching pain in the buttock region aggravated by activity following strenuous exertion during basketball in one instance and football in the other. One student was seen at the age of 15 complaining of pain in the left buttock and hip region following strenuous football practice. X-rays at that

time revealed the typical irregularity in appearance of the left ischium and subsequent x-rays after bony repair became apparent revealed that there had been some involvement of the right side also. This patient with only bed rest has now regained complete recovery of the use of both hips and has resumed his activities with no evidence of any disability.

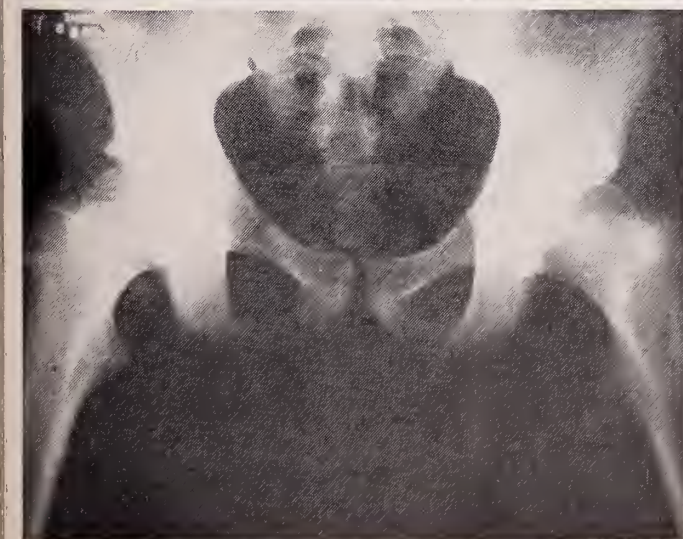
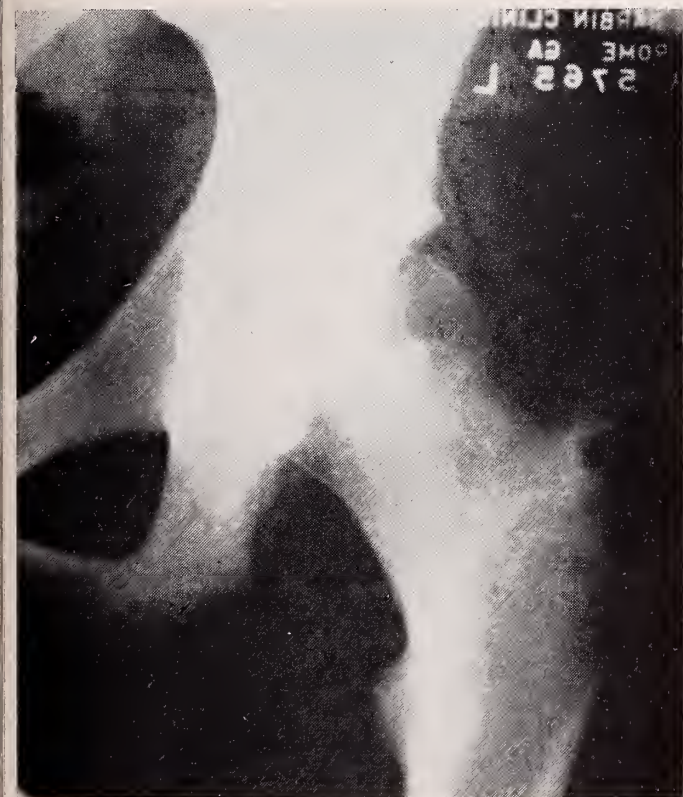


The other student was seen at the age of 16 with pain in the right hip after playing basketball. After x-rays revealed the typical bone findings the patient was placed on bed rest for a short period of time with subsequent limitation of running activities and eventually had some discomfort in his opposite ischium. X-rays revealed bilateral involvement.



Again complete recovery was readily achieved and the patient has resumed athletics and the only finding of note upon subsequent physical examination being tightness of the hamstrings bilaterally. This condition may have existed prior to his injury and may be a factor in the etiology of this disorder.

It is of interest that bilateral pain developed in only one case although x-rays revealed bilateral change in the apophysis in both patients. Neither



ISCHIAL APOPHYSITIS / *continued*

student has been found to have any permanent deformity or residual impairment and complete healing occurred with only conservative treatment.

Discussion

1. Ischial apophysitis with its associated complications has been reviewed and x-ray evaluation of young athletes with hip pain is strongly recommended.

2. A review of the literature reveals that the best treatment for avulsion fractures of the ischium is open reduction.

3. Two additional cases of apophysiolysis are presented which recovered without complication on conservative care.

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Presented at the 107th Annual Session of the Medical Association of Georgia, May 8, 1961, Atlanta, Georgia.

WATER SPORTS TOP SUMMER FUN

AS THE WARM WEATHER COMES again to the state, scores of men, women, and children will gather up fishing gear and swim suits and head for the cool retreats of streams, lakes and seashore.

Across the state of Georgia, the natural beauty and recreational facilities of 15 major reservoirs, 17 large rivers and countless thousands of smaller lakes, ponds and tributaries, annually lure Georgians and out-of-state visitors to set sail upon their glistening waters.

Water is like a magnet. Fresh or salt, it attracts them all. It's relaxation for the very old, a delight for the young. The whole family can enjoy it together, from the swan-diver right down to the dog-paddler. Anyone can shout "Come on in, the water's fine!," but it's not always fine. It's a mixed blessing—part magnet—part menace—depending upon how you use it.

During 1959, over 180 persons died in Georgia of accidental drowning. According to National Safety Council figures it is estimated that nearly 34 persons die per day during the summer months due to accidental drowning in waterways of the nation. Most of these deaths were unnecessary and avoidable, and the shockingly high figure points up a strong need for swimmers, boaters, and fishermen to learn water safety and first aid before embarking carelessly on the water.

Unfortunately, most of the people in the United States do not know how to swim, and that's the basic reason why drowning becomes one of the most important causes of accidental death in the summer.

So if you are planning to swim this summer, and it's fine exercise as well as pleasant recreation, pay attention to the rules of water safety. Whenever any member of the family gets that irresistible urge to swim or sail, its time to review the common do's

and don'ts of water safety; check the swimming ability of each member of the family to know how much independence each can be allowed, and above all, encourage a respectful and sensible attitude towards water. It can be friend or foe.

Learn to swim well. Self-taught "dog paddlers" too often think they are swimmers and overestimate their abilities. Know your limits as a swimmer and stay within them.

Never swim alone. Always have help at hand, preferably a lifeguard with the knowledge and equipment for rescue. Don't swim after dark for the same reason. It is too hard for even an expert to assist you in the dark.

It is dangerous to dive into water of undetermined depth. Submerged rocks or logs may knock you out. Sudden plunges into cold water should be avoided. Go in gradually, and remember that you tire faster in cold water. Don't plunge into water when you are overheated, and wait at least an hour after eating.

Never jokingly call for help, and don't splash or annoy others who are timid in the water. Horseplay and pranks cause many water accidents each year.

Even strong swimmers are subject to cramps and bad guesses on their endurance. If you want to swim for any distance, have someone follow you in a boat.

Don't let children take beach balls, inflated animals or light rubber rafts in the water. A gust of wind often blows them beyond reach, and in trying to retrieve them, a child may get beyond his depth. This is a point adults should keep in mind, too.

In recent years, recreational boating has increased to the point where it has become America's top family sport. More navigable waters continue to be opened annually, drawing more people to them for recreation and intensifying the need for observance of water safety practices and regulations.

Georgia's Health

MEDICAL ASPECTS OF SPORTS

LAST YEAR as well as this the Medical Association of Georgia in cooperation with the Georgia High School Association, the Georgia Athletic Coaches Association, the Georgia Department of Public Health, and the Georgia Department of Education will present a program on the "Medical Aspects of Sports." Last year's meeting was very fruitful for the doctor and coach alike. This year the program will be held in Macon on August 11-12, 1961.

The faculty on last year's program was:
Walter Bloom, M.D., Atlanta, Research Physiology; Sam Burke, Thomaston, Executive Secretary, Georgia High School Association; Richard Copas, Auburn, Alabama, Trainer, Auburn Tigers; Edgar Fincher, M.D., Emory University, Neurosurgery; Victor Della Giustina, D.D.S., Augusta, Public Health Dentist, Richmond, Co.; Hugh Hailey, M.D., Atlanta, Dermatology; Kenny Howard, LaGrange, High School Coach; Earl Lewis, M.D., Macon, General Surgery; George McCluskey, Columbus, Physical Therapy; M. D. Pittary, M.D., Toccoa, Internal Medicine; Sam Richwine, Athens, Trainer, Georgia Bulldogs; John Robinson, M.D., Americus, General Surgery; and O. F. Whitman, M.D., Atlanta, Director, Local Health Branch, Georgia Department of Health.

These are some of the papers presented at that time.

Physical Conditioning

Presented by
Kenny Howard, Chief Trainer
Auburn University, Athletic Department
Auburn, Alabama

The purpose of conditioning is the gaining of endurance. The first necessity for conditioning is mental preparation on the part of the athlete. The athlete must be willing to drive himself to the point of painful fatigue. The body must be tuned up to function to maximum efficiency.

An important factor in endurance is strength. Early in training the athlete has a tendency to over exert him-

self to accomplish the task presented. As training progresses the over exertion diminishes as his body adapts to the amount of strain needed for the job which in turn increases the athlete's endurance. In training there is an actual increase in strength.

Everyone in athletics attempts to seek the best methods of conditioning their athletes. The greatest advancements in athletic performance and conditioning have been made in track and field. If we look into this we will see that some of the well-known runners trained on a year-round basis.

Name	Event	Years Days/ Months/			Country
		Training	Week	Year	
Bannister	Mile	14	5	9	England
Courtney	1/2 Mile	7	5	10	U.S.A.
Delaney	Mile	5	5	10	U.S.A.
Elliott	Mile	—	7	12	Australia
Haegg	Mile	9	6	9	Sweden
Landy	Mile	11	6	12	Austria
Zatopek	Marathon	11	7	12	Czechoslovakia

The athletes in the above table were in events requiring endurance. Football and basketball all require endurance. It is the authors opinion that a year-round training program for athletes would result in better conditioning. A good year-round program would include participation in various sports. Wrestling and weight lifting are good off-season activities if well supervised. Summer jobs should be of the hard labor type. Walking remains one of the best exercises in overall conditioning.

An outline of conditioning for a particular sport should be divided into two different parts.

1. Off the field
 - (a) Rest or sleep—nine hours is enough sleep—naps tend to make one sluggish and de-conditioned. Rest cannot be stored.
 - (b) Eating—Breakfast is most important and the athlete should avoid over-eating.
 - (c) Regularity—should be present in all activities—Eating, Sleeping, and workouts.

MEDICAL ASPECTS / continued

2. On the field

- (a) Warm-up—Should start with slow stretching exercise with an increase in tempo.
- (b) Actual practice—Periods of work, taking a lot of work should be followed by periods requiring less effort allowing some recovery time—Small amounts of water during practice are very beneficial.

It is early in the conditioning period that the athlete is most likely to be injured. With fatigue, the finely skilled motions become gross motions and graceful coordination is lost. Further, the athlete is not mentally alert.

The question is frequently brought up as to when an athlete is in condition. It is my opinion that he is in good condition when he meets the following:

1. His recovery period from exertion is minimal (30-45 Sec.).
2. His movements remain well coordinated to the point of fatigue.
3. His resting pulse rate is 60-68.

High School Coach

Presented by
Oliver Hunnicutt, B.S., Coach
LaGrange, Georgia

All the greatness of football is not worth the life of one player, if that life were lost unnecessarily. The proper functioning of a team necessitates the full cooperation of the coach, the player, the parent, the principal, and the physician.

The coach is responsible for the proper functioning of each of these members of his "coaching team." He must strive to develop and maintain a good relationship with each and every segment of this "team." He is responsible to see that the player is well coached; this includes the proper physical conditioning as well as the best technique of aggressive playing. Physical conditioning has been achieved at the beginning of the season by having practice sessions in the early morning and late afternoon, or night to avoid the heat. As the players become more adjusted to the workouts, heavier work and heavier clothing is added. Still later the practice sessions are gradually moved closer to the hotter part of the day to condition the players to the heat. The players are taught the meaning of good conditioning in spring practice; they can intelligently develop themselves during the summer so they report to fall practice in relatively good shape.

The school administrator is responsible for seeing that funds are available for the best equipment. The LaGrange Junior High boys are furnished with the same quality equipment as the first string varsity high school team. The number of participants out for a team should not exceed the number which can be equally provided with the best protective equipment. The school administration must provide proper playing fields and practice fields.

The physician is responsible for diagnosis and treatment of injuries. He should be on the sidelines or on

the bench, not in the stands. He should rule whether a previously injured player could be returned to the game. And, a boy should never be played against the team doctors orders. The doctor should check in the dressing room before game time and at the half time. The Troup County Medical Society appoints a physician to be with the team at each game. This physician renders emergency treatment and the player is subsequently cared for by his family physician. The doctor does not run the football game and the coach does not make the diagnosis of injuries.

The player (athlete) has a responsibility. He must go by the rules prescribed for the other students and for the team. When he is injured he should report the injury, not try to hide it. He must fulfill his part relative to the training rules.

The parents have a responsibility. They should be informed by the coach relative to all of the fine equipment, training, coaching, and medical supervision they are being provided. Then they must be made aware of their part in the proper diet, proper rest, and proper study habits of their athlete.

(Chairman: In the discussion period, Doctor Sappington of Thomaston, Georgia, stated that he felt that a County Society appointing a different physician to act as the team physician for games on a rotation basis was the second best solution. He felt that a physician interested in the team and interested in athletics, who regularly attended the games would be more familiar with the individual personalities of the players, would be better able to evaluate their new injuries, and would be better informed relative to their past injuries and past medical history. He compared the rotation of physicians with a different one for each game to the possible rotation of coaches with a different one for each game and wondered how effective a team could work under such coaching. Doctor Sappington's ideas were well supported and if there is a physician in the community who is especially interested in sports then he should be allowed to be the team physician. If, on the otherhand, there is no one in the community interested enough to take the responsibility of being the team physician, then the county medical society is commended for seeing that one of its members be present at game time to fulfill the position of team physician to the best of his ability. It is definitely a part of our community responsibility.)

Chest and Abdominal Injuries

Presented by
W. E. Lewis, M.D.
Macon, Georgia

The author stated that the subject which he would discuss consisted of only a small percentage of athletic injuries but the injuries which do occur on the field have a dangerous potential.

Chest Injury

The most common chest injury is rib fracture. This injury is seen primarily in ends and linebackers, who throw body blocks with their chest cages with the arms extended. In evaluating a boy with a chest injury, pain on deep breathing and pointed tenderness are im-

portant. Every such case should be kept out at least one play and at this time should be evaluated on the sidelines.

Rib fracture in the athlete where the rib is not compounded (protruding through the skin or into the pleura) is a painful but not a serious injury. These patients should be kept out of the game for three weeks if they have no complications. Intercostal nerve blocks used in an effort to keep an athlete in a game have no use in high school circles. Strapping of the chest restricts respiratory movement if it is tight enough to give good relief of pain and consequently should not be used in a strenuous game such as football.

Abdominal Injuries

Probably the most frequent serious abdominal injury in football is the ruptured spleen. There is severe bleeding if the spleen is ruptured. Most ruptured spleens come from piling on or from a direct blow to the left upper quadrant and are frequently associated with broken ribs. A boy with a ruptured spleen is a sick athlete. He frequently complains of pain in the left shoulder. The abdomen is rigid. This is more so in the left upper quadrant. The pulse is rapid and thready. This boy should be removed by a stretcher from the field. Treatment of the ruptured spleen should be surgical removal.

Ruptured liver should be mentioned. This is likewise a serious injury. Essentially its characteristics are the same as a ruptured spleen except that it is the right upper quadrant and the pain is referred to the right shoulder. These athletes complain of severe nausea and frequently vomit. The treatment is the same as with a ruptured spleen in that they should be removed from the field by stretcher and hospitalized.

Ruptured bladder is a rare athletic injury but does occur. An important fact to remember is that an empty bladder does not as a rule rupture. The etiology is a traumatic blow in the pubic area. A patient with a ruptured bladder will have a rigid abdomen in this area and micturition will be bloody. This patient should be sent by ambulance for definitive hospital treatment.

Kidney injuries are not infrequently seen. An athlete who has a suspected ruptured kidney should be checked clinically and kept under close observation. Intravenous pyelography should be carried out in most cases. The treatment for the most part is conservative.

In many cases of serious injury the degree of seriousness is not known until the patient can be fully examined. For this reason a plea is made for more use of stretchers to remove players from the field.

A word should be said regarding the correct wearing of hip pads. Hip pads should be worn to protect the kidneys and spleen and not pushed down below these areas. Correctly fitted and correctly worn hip pads and rib pads will protect the athlete from many of the above mentioned injuries.

Dental Injuries

**Presented by
Victor Della Giustina, D.D.S.
Public Health Department
Augusta, Georgia**

A good oral examination should be included in the

good physical examination given in the pre-season check-up.

There has been a great decrease in the rate of injury to the face and teeth; this is the result of the correct and improved type of equipment, especially the helmet, the face guards, and the individually fitted mouth pieces.

Not all different types of manufactured mouth pieces have proven successful after being tried in Richmond County. The player needs a mouth piece that will fit his mouth individually so that he can talk well when the mouth piece is in place. The mouth piece should fit so that it will not get in the player's way and bother him. It must be comfortable. It must fit so well that it can't be knocked out. (Doctor Della Giustina put in a mouth piece which had been made for himself and demonstrated his ability to talk understandably throughout a great deal of his presentation with the mouth piece in place.) The individually fitted mouth pieces have diminished the injuries to the teeth to the extent that no teeth were lost in Richmond County this last year as a result of football injuries. It is the opinion that the mouth pieces have absorbed a considerable amount of shock to the mandible and thus, have diminished the frequency of brain concussion. (Doctor Della Giustina presented slides demonstrating many patients who had various and sundry combinations of tooth injury as a result of athletic competition without mouth pieces.)

The individually fitted mouth pieces for each and every high school football player resulted from a joint project in Richmond County. The local Dental Society, the Public Health Department of Richmond County, the dental laboratories, the Board of Education, and the Athletic Directors and Athletic Departments of the schools all put their best efforts together to make this possible. The dentists volunteered their services for making the impressions. The molds were made from the impressions and these were sent to the dental laboratory. The mouth pieces were made by the dental laboratory and the only cost was the laboratory fee of approximately four dollars for each mouth piece. (Doctor Della Giustina demonstrated how an impression was taken, the making of the mold, how the mouth pieces were made, and told how such a program could be set-up by the coaches and dentist in their own localities. Trainer Sam Richwine entered into the discussion and told how they had made the similar individually fitted mouth pieces for the players at the University of Georgia. At the training sessions that evening, both of these gentlemen, Doctor Victor Della Giustina and Sam Richwine, were kept busy with their respective groups in demonstrating the simplified technique of producing these individual mouth pieces.)

It should be mandatory that all football players use these mouth pieces:

1. to prevent fractures of the teeth.
2. to prevent aspiration of fractured teeth which can sometimes bring on a lung abscess.
3. to decrease the frequency of fractures to the mandible and maxilla.
4. and to decrease the type of brain concussion which results from the impaction of the mandible against the base of the skull.

Prevention of Athletic Injuries by Equipment and Rules

Presented by
Sam Burke, A.B., M.A.
Executive Secretary, Georgia High School
Association
Thomaston, Georgia

Essential factors in sports which should be watched for the health of the athlete are:

1. Proper teachings of skills.
2. The proper condition of the athlete.
3. The approved officiating under rules code.
4. Properly constructed and fitting equipment.
5. Applications of good sound health principles in taking care of the equipment, the dressing rooms, etc.
6. First-aid for preventing injuries and treatment of injuries.
7. Proper medical supervision and medical care.

Approved Officiating Under Rules Code

Athletic rules changes in the last ten to 15 years have been designed for safety. In baseball, play obstructions in double plays has been ruled out. Interfering with a hit ball to the short-stop by a player going from second to third automatically puts the runner out because of the interference. In track, a runner must be two strides ahead before he can cut in front of another runner. The lighter weight shot-put and discus have been adopted to cause less strain in the high school athlete. The track man has been limited in the number of events he may enter in order to prevent undue fatigue with the result of increased injury. The landing pits on the far side of the high-jumps and the pole-vaulting has been built up in order to break the distance of the fall. Holes cannot be dug in the track for starting. Pushing another runner is disqualifying. Falling at the end of a sprint must be discouraged.

In girls basketball, the rules have been changed in order to decrease the frequency of the jump off. Girls play a shorter time period than boys. There are six players in girl basketball on the team and half of them are limited in their action to their half of the course.

In football, piling on is caused by a slow whistle; nor should the whistle be too fast. The defensive player may recover a fumble and run as it cuts out the piling up by allowing the defensive player to pick up and run with a fumble. This came about as a safety factor. Crawling must be stopped. Roughing the kicker was ruled out because of the injuries it was producing. The first year the face mask was used, many players used the mask as a handlebar in order to twist the opposing player's head; this was ruled illegal and a 15 yard penalty. Clipping from behind is illegal. Striking with the forearm is a 15 yard penalty with a disqualification. Liberal substitution rules are important as they prevent fatigue and thus, reduce injury. Anytime a boy is hurt or apparently hurt he must come out of the ball game for one play. This is mandatory.

The Proper Condition of the Athlete

Some boys may be trained in specific areas in a track or baseball program even if he is not able to play foot-

ball, and you might help him by building up a deficient portion of his body.

Proper Constructed and Fitting Equipment

Proper fitting of equipment is most important. The shoes should fit because blistered feet can put a boy completely out of action (no hoof no horse). A helmet which does not fit may even help cause a concussion. Equipment is being made well and made for the protection of the athlete. Fifteen years ago one flat piece of leather was made into a helmet. And, if you wore it you were a sissy; therefore, a rule was made that the helmet had to be worn. Head gears may now be observed with various types of protective pads and of suspended and non-suspended crowns. One of the main problems with head gears is not the person who is wearing it getting hurt, but the boy that he runs into (the other player). Hip pads are not made in the pants like they used to be, but are much better and with rounded edges. (Chairman: We recently encountered a team having considerable difficulty with many of their players having severe bruises of thigh muscles and with a high frequency of myositis ossificans in these muscles. This increasing difficulty beyond the normal had been brought about by the sharp edges on the thigh pads digging into the thigh muscles while doing contact work.) All of the sharp edges are being removed from the equipment to protect the other player. There are many types of face bars; without the bars 52.5 percent of the injuries were dental or facial. Face bars will not stop the injuries completely, but they do cut the injuries down greatly and must be worn. Mouth pieces should be used to protect the teeth. Good fitting ones of good make can be used and the quarterback can talk so he may be easily understood. You must have a mouth piece which will stay in. The player must be able to talk with it in his mouth. The piece should not be able to slip back into the back part of the throat.

Broken collar bones are not now frequent due to the improved construction of the shoulder pads. We still have shoulder separations due to the injuries on the outstretched arm. Cleats are real trouble makers and are of all types and sizes and shapes and makes. (Chairman: The shorter cleats especially on the heels will help prevent the fixing of the foot in the backfield men and will thus, decrease the frequency of cartilage injuries to the knee.)

In track, the oval tipped javelin has replaced the formerly spear pointed one. The hurdles have been constructed so that they will turn over more easily when struck and thus, are less likely to throw a runner off balance when he accidentally strikes one. Also, the high school hurdles have been lowered as the runners are not as long legged as the average college runners. The hurdles were pulled closer together because the stride of the high school athlete was not as long.

Care of the Equipment

One football squad was lost for two weeks because the field was not properly marked. Marble dust was not used, but slack lime was used and this produced a considerable skin irritation and burning. Lime of any type is prohibited by rule.

The carelessly placed bench along the side line is

dangerous. Stairways and gates should not be near the football field.

Dressing room floors should not be slick. Clean towels should be used. Towels, socks, jockey straps, and some types of the shoulder pads can be placed in the washing machine.

Proper Medical Supervision and Medical Care

All injuries, no matter how minor, should be reported. A previous injury record should be available on all players. Medical supervision should be available in any way it can be had, but the best is the regular team physician, because a physician regularly caring for the team would better know the injury and health background of a good many of the boys.

Medical Basis for Restriction from Athletics

**Presented by
M. D. Pittard, M.D.
Toccoa, Georgia**

The degree of functional efficiency in sports depends upon the degree of physical fitness, or conversely, the degree of physical impairment, as well as it depends on the degree of desire! Without desire, no amount of physical conditioning or inherent ability will result in a good athlete.

Contact sports should be avoided by boys having only one kidney, one testicle, one eye, and by those having repeated brain concussions, or severe heart involvement. However, if the desire were there, an individual with one of these conditions could make a good specialist on the team, possibly as an after point kicker or as a team manager. In other words, if a boy with a physical defect at the junior high or high school level has a tremendous desire to be associated intimately with the sports activity of the school, every effort should be made by the coach, team physician, and school administrator to find a suitable position for this individual.

Correctable physical abnormalities such as hernias, hydroceles, hemorrhoids and bone spurs (exostosis) should be treated before engaging in physically demanding sports.

Minor physical defects should be considered when placing the athlete in a given position on the team. The boy hard of hearing should be guard on the football team so he can watch the center hike the ball for his cue to charge, or he should be the discus thrower on the track team, not the sprinter. The near sighted or color blind youngster will make a better interior lineman than he will a halfback, quarterback or end.

Recent injuries and their relationship to sports are discussed by other members of the panel, but let me re-emphasize, that an athlete who is out of practice and play for a week or two with an injury is likely to be out of condition for a week or two after returning to the fray. Don't look for him to play the full game the first time he returns to the team or he may have another injury.

The ages of the contestants is of greatest importance—not their chronological ages (age in years), but their physiological ages (physical size, sexual development, and degree of skeletal maturity). These rapidly growing years from the last year of grammar school through high school present the team physician and the coach

with a very heterogeneous group of individuals, thus, a very heterogeneous group of problems. A practical gauge of maturity sufficient for participation in contact sports is the development of coarse, curly pubic hair.

A primary concern should be that our athletic activities be available to all students. One of the main objections to our athletic program among our children is that the emphasis is on winning. In order to have a winning team, the coach must select from the student class the best prospects and must concentrate his attention of these few. The greater mass of the student body is left to sit, slump, sulk, and generally get bored. And, this should not be their lot. All physically able students should be participants in some type of physical fitness program. There remains a great deal yet to be done along this line. Intramural teams should be organized so as to develop teams of near equality, not all the best on one team and all the worst on the other. These teams should also be organized according to physical size and physiological maturity, not according to age in grade alone. Place the big boy against another big boy, the smaller across from his near equal.

Most parents should be excluded from participation with a team having one of their offsprings as a member. We must admit that exceptional parents do exist in this world, but for the most part they create considerable chaos and they very frequently unconsciously project their unaccomplished desires into their offspring and push them beyond their emotional and physical capabilities. Such a child is a candidate for an athletic injury. This creates a bad situation for all members of this team. Other youngsters who are more subject to injury are those whose aggressiveness is out of proportion to their ability, and conversely, those who are somewhat timid or fearful and hesitate momentarily before engaging the adversary, even though they have good ability.

Granted that the primary purpose of the school is academic and not athletic, we must remember that health in body is most important to proper mental development.

Evaluation of Head Injuries in Sports

**Presented by
Dr. Edgar Fincher, Professor of Neurosurgery
Emory University, Atlanta, Georgia**

The author stated that head injuries are common to all sports, but are not a common athletic injury. Physical combat per se is conducive to head injuries. The protective equipment used decreases the percentage of serious head injuries.

An athlete with a suspected head injury should have the benefit of a complete neurologic examination. The stage of consciousness should be evaluated. Abnormal behavior such as thrashing, fighting and such are definitely abnormal. This means that something is going on in the athlete's brain. A serious picture is presented by the patient who fails to respond to any stimulation. Other vital signs are observed. The respiratory activity of the patient is changed with head injury. An injured player who has reasonably normal respirations in rate and depth and maintains good color is on reasonably safe ground. Certain phenomena take place in the brain as the intracranial pressure rises. The systemic blood pressure rises and the pulse slows down. A slow pulse

MEDICAL ASPECTS / *continued*

may be normal but with alteration of other vital signs this would be important. A pulse rate of 85 to 110 without other abnormalities would place the patient on fairly safe ground.

A complete neurologic examination is important in any suspected head injury and should be recorded in the athlete's record for future needs. Neurologic deficit such as Horner's syndrome, wrist drop, etc. are indicative of nervous system damage.

Recently a group of neurosurgeons sent out a questionnaire as a project on athletic injuries. The questions and compiled answers on the questionnaire were as follows:

1. Q. How would you handle a player that is momentarily unconscious?

A. Should be held out for at least one week.

2. Q. How would you handle a patient who was unconscious for less than five minutes?

A. He could resume his training activities in one week but no combat. He should be out at least seven to ten days from body contact.

3. Q. Unconscious for more than five minutes?

A. Activity should be very limited without any competition or combat for two weeks.

4. Q. A contusion without evidence of brain deficit?

A. This is a very difficult group to evaluate. They have had a long period of unconsciousness and these are the ones that can give trouble as late as three weeks, and therefore should be held out for at least three weeks.

5. Q. The victim of amnesia lasting from five to 20 minutes without physical handicap and without neurologic deficit?

A. This athlete should be held out three to four days, but should not engage in contact sports for two weeks.

6. Q. How do you handle a linear fracture of the skull in an athlete?

A. A blow hard enough to fracture a skull is a real impact. This person should be out for three to four weeks at the very minimum.

7. Q. How would you handle a victim of repeated amnesia?

A. If the athlete has repeated amnesia from trauma he should be out for a full season because of late possible complications such as latent epilepsy and protracted amnesia.

Concussion is an ill-defined lay term used by many physicians. It is used to describe anything from a simple scalp scratch to massive fatal brain destruction. Concussion is a condition of lower functional activity without visible structural change brought to an organ by trauma, and consequently this word should be used guardedly.

In the discussion of the paper with Dr. Fincher two questions from the floor were brought up which are included because of their importance. The first question was regarding the athlete who has had spontaneous bouts of nontraumatic loss of consciousness. Doctor Fincher felt that this athlete should be watched because he may have a potential convulsive disorder and contact sports should be avoided. The other question asked was whether the child with minor degrees of epilepsy

should be allowed to participate in sports. Doctor Fincher stated that these children should not be allowed to participate in contact sports in his opinion.

Skin Diseases in Athletes

Presented by
Hugh Hailey, M.D.
Atlanta, Georgia

I. Conditions Causing Skin Ailments

- (1) Hot weather
- (2) Humidity
- (3) Locker-shower-dressing rooms
- (4) Sweaty clothing
- (5) Sweat itself
- (6) Natural predisposition

II. Prevention

- (1) Air conditioned dressing rooms
- (2) Daily change of sweat shirts, athletic supporters, socks
- (3) Dry heat to leather gear
- (4) Exposure to sunlight of shoes, head, shoulder and pants gear
- (5) Personal Hygiene
 - (1) Soap and water baths three times daily
 - (2) Liberal use of talc

III. Skin ailments

- (1) Heat rash
- (2) Chafing—flexures, armpits, groins
- (3) Fungus infections—feet and groins especially
- (4) Boils, abscesses, cellulitis, erysipelas
- (5) Plantar warts and calluses
- (6) Warts on fingers
- (7) Blisters

IV. Treatment to avoid

Multiple applications irritating to susceptible people.

- (1) Iodine
- (2) Merthiolate
- (3) Mercurochrome
- (4) Metaphen
- (5) Chlorine products
- (6) Benzocaine preparations

V. Treatment of Benefit

- (1) Heat rash—rubbing alcohol (70% ethyl) followed by liberal application of talc.
- (2) Chafing—calamine lotion—1% phenol
- (3) Fungus Infections—local
 - (1) 10% Salicylic acid in alcohol
 - (2) Desenex cream and powderSystemic
 - (1) Griseofulvin—by prescription only
- (4) Boils
 - (1) 5% Ammoniated mercury dressings
 - (2) Do not cut. Do not squeeze.
- (5) Abscesses
 - (1) Incision and drainage
- (6) Cellulitis
 - (1) Penicillin—large doses
- (7) Plantar Warts and Calluses
 - (1) Trimming—40% Salicylic acid pads
- (8) Warts—elsewhere—liquid nitrogen

The Team Physician

**Presented by
John Robinson, M.D.
Americus, Georgia**

Pre-Season History and Physical

The first responsibility of the team physician relative to good medical care is an adequate pre-season history and physical examination. The history of past illnesses and past injuries is most important. The physical examination should include a testing of vision and hearing, and not merely a visual appraisal of the athlete to see that he is vertical and breathing. Laboratory test should include a hemoglobin and urine. A stool specimen may also be run on the slightest indication. Relieving a youngster of worms may produce a ten second man out of an otherwise slow-poke. The American Medical Association has plenty of special forms for the history and physical examination on athletes and if you will obtain these you will find them to be excellent.

Record of Injuries and Illnesses

The team physician can easily keep a record of the injuries and illnesses of the players from year to year and throughout the season by the mere keeping of satisfactory office records. A running tabulation of injuries and illnesses should not be the task of the coaching staff.

Referral

The team physician has a responsibility to his colleagues to give first aid to the boys when they are injured. The player can then be referred to his physician of choice when he or his family desires treatment by someone other than the team physician.

Advise With School Authorities and Coach on Medical Cost, Finances and Insurance

This is a most important function and can be handled adequately only through the conferring and advice of the team physician. It would also be excellent to obtain the consultation of an insurance agent in the locality. With such cooperation a satisfactory insurance program can be established.

Check Dressing Room

The physician should stop by the dressing room before the game, at halftime, and after the game to inquire as to any need of his services. He can frequently help in the strapping of some of the ankles as a prophylactic measure.

Be Available at Practice Hours

The team physician should be available during practice hours and the coach should know where he can immediately locate the physician in case of need.

Know the Players

The team physician needs to be interested in sports. He should have a philosophy about treating high school boys as they are not yet grown men, but they are too

big for little boys, and thus demands some special understanding. He needs to understand some of their problems as well as treating their injuries. He should see that the athlete remains as much a part of the team as possible when injured and until he can resume normal athletic activities. He can be a better judge of the relative seriousness of bruises and sprains with knowing the personality of the player.

Sit on the Bench

Don't just attend the sporting events. Sit on the bench on the sidelines. The doctor cannot do the athlete justice while sitting far up in the stands. For example, if a boy comes out of the game dazed, the doctor can sit by him and talk to him. In the course of conversation the player can be evaluated relative to disorientation, incoherence, and other mild signs of concussion.

Wise Up on Athletic Injuries

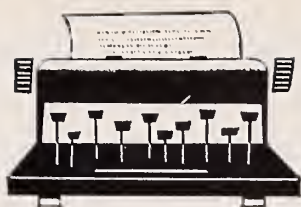
The physician should be alert to the type and mechanism of the acute injuries associated with the sport. Every suspicious sprain should be proven to not be a fracture. A "sprained" wrist is infrequently an unnecessary nonunion of a carpal scaphoid when finally x-rayed a year or two later. A "sprained ankle" can become a chronic recurrent subluxation of an ankle (weak ankle), if stress x-rays are not taken to demonstrate the presence of ruptured ligaments at the time of the acute sprain. Acute sprains of the ankle or other joints are best treated by immediate cold compresses, a compression bandage, and elevation for as much as 24 hours if possible. This treatment sometimes saves two to three weeks of disability. Procaine (anesthesia) injections are condemned as a method to allow a boy to be playable when he is injured. Injections should not be performed on the field or in the unsterile atmosphere of the training room. Injections are a minor operation. They are for treatment and not merely for temporary anesthesia. They need to be given under sterile technique.

Confer With Coach on Vitamins, Training, First Aid Kits, Etc.

The team physician can save the school and its athletic department a considerable amount of money in advising relative to the matters. The team physician should work with the coach and should strive to have the friendship and cooperation of the coach and trainers.

Make Decisions Regarding Playability

The team physician should make the decisions relative to removal of a player from the game, or for returning him to the game in case of injury. The coach and trainer should not be burdened with such a problem. (At this point, in a joking and good humored manner, but with a serious undertone, Coach Oliver Hunnicutt stated that the coach or trainer should not become so interested in the medical care that he begins to practice on the players or advise his physician in how to treat them, and likewise the physician should not become so ardent a fan that he tries to help the coach with the tactics of the game).



editorials

Thomas Wright Goodwin Holds Key Position

THOMAS WRIGHT GOODWIN resigned as Speaker of the House of Delegates this year and was elected as President-Elect of the Medical Association of Georgia at the 107th Annual Session held in Atlanta.

Dr. Goodwin received his B.S. from the University of Georgia in 1926, M.D. from the Medical College of Georgia in 1930, M.S. Surgery from the University of Minnesota in 1934. He spent his internship at University Hospital in Augusta and his residency as a Fellow in Surgery, Mayo Foundation, Rochester, Minnesota in 1931-1935 and became a Fellow of the American College of Surgeons in 1942. Dr. Goodwin was appointed as Associate Clinical Professor of Surgery in 1935 at the Medical College of Georgia.

He served in the U.S. Navy from September 1942 to March 1946 and has engaged in active practice in surgery in Augusta since that time. Also Dr. Goodwin is a Lt. Commander in the U.S. Naval Reserves.

Dr. Goodwin is the Past President of the Georgia Chapter of the American College of Surgeons, Member of Southeastern Surgical Congress, Past President of the Richmond County Medical Society, Speaker of the House of Delegates of the Medical Association of Georgia for nine years, former Member of the Georgia State Board of Health, Member of the Richmond County Board of Health, Chairman of the Richmond County Medical Society Committee on Hospitals and Related Medical Facilities, and Alpha Omega Alpha. At the present he is on the attending staff of University Hospital and St. Joseph's Hospital in Augusta. He is a member of

the Augusta Rotary Club and an Elder of the First Presbyterian Church there.

Dr. Goodwin married the former Isabelle Walker North and they have four children and live at 3026 Bransford Road in Augusta.

Congratulations to our President-Elect and the Association for having the good judgment to elect such a capable man to this important office.



Sports and Medicine

IN RECENT YEARS preventing, diagnosing, and treating injuries related to athletics have gained increased attention from physicians, trainers, coaches, and other interested groups. The physician is becoming more a part of the "high school team." The coach and trainer have leaned toward the medical team for improved athletic performance through better methods of conditioning and training. The school administrators have sought their local physicians' advice in setting up insurance coverage programs. Medical expenses have been mounting even with physicians giving their time and efforts freely.

Much of the knowledge related to athletic injuries prevention, training, etc., has not been readily accessible.

Doctor Grady Black and fellow members of the School Child Health Committee of the Medical Association of Georgia desired to have a postgraduate course related to the Medical Aspects of Sports. They felt this would aid the interested physicians and would create an awareness among other physicians. They felt it would bring the coaches and physicians together to create mutual understanding.

The common objective would be prevention of illness and injury and intelligent treatment of any injuries which might occur. The result would be an increase in the quality and quantity of good athletes.

Such a course was carried out in Columbus, August 12-13 of last year under the sponsorship of the Medical Association of Georgia in cooperation with the Georgia High School Association, Georgia Athletic Coaches Association, Georgia Department of Public Health and the Georgia Department of Education.

The presentations were interesting, understandable, and useful to the coaches and physicians alike.

The audience participation was as stimulating as the presentations. A representative collection of abstracts from these presentations is presented elsewhere in this issue.

A second session devoted to Medical Aspects of Sports is to be presented in Macon, August 11-12, 1961. All physicians are urged to encourage their local coaches, trainers, and physician friends to attend this highly enlightening meeting.

For further information contact Dr. Jack C. Hughston, 1316 - 13th Avenue, Columbus, Georgia.

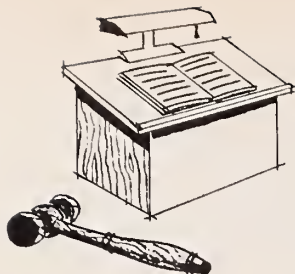


"OUR INNOCENT ONES"

"Our Innocent Ones," a story of our physically handicapped children, was presented on WALB-TV in Albany, Georgia on Wednesday night, April 26th.

"Our Innocent Ones" was the third in a series of medical documentaries presented monthly by WALB-TV and the Dougherty County Medical Society. This type of educational program has been the most acclaimed local series that has ever been presented in WALB-TV's seven year history—our ultimate goal . . . education.

Doctors appearing on the program were: Dr. John Meier, Dr. Frank Thomas, and Dr. Dean Paschal.



president's letter



FRED H. SIMONTON, M.D.

COMMUNICATIONS AND ACTIVITIES OF THE MEDICAL ASSOCIATION OF GEORGIA

LIKE ANY ORGANIZATION which engages in a number of activities, the Medical Association of Georgia relies heavily on communications as a basic ingredient to the successful performance of the many jobs it undertakes. The old principle of the left hand knowing what the right hand is doing is extremely important in a organization as complex and extensive as ours.

In years past, one of the weaknesses of the overall MAG operation has been that of not successfully communicating MAG programs, activities and policies to the members and in receiving member reaction to these matters in return. This is not a unique problem of the Medical Association, but is one which all similar organizations have to face. It requires constant attention to be corrected and stay corrected.

Amendments to the MAG Constitution and Bylaws, adopted by the House of Delegates at the 1961 Annual Session, will do a great deal to improve this situation. In essence, these amendments streamline the operation of the Association by eliminating several committees and regrouping the function and jurisdiction of these committees for more efficient organization.

Prior to this committee reorganization there were eight Council Committees, 20 Standing Committees and a number of Special Committees. By the action of the House of Delegates this has been changed to provide for four Association Committees and 12 Boards which will assume the responsibilities and functions of the Standing Committees. Reorganization also provides for the appointment of Special Committees at any time when the need arises. These Committees would be appointed by the President, subject to approval by Council, and their terms of office would run concurrent with that of the appointing President.

The Boards will be directly responsible to the Council of the Medical Association of Georgia and will make their reports directly to this body. Each Board will have a maximum of 15 members, one of which must be a member of Council. The purpose of this is to further improve internal, two way communications between the Boards and the Council.

It is hoped that receipt of reports from Committees and Boards will always be timely. I urge each subcommittee to be active in its affairs and to report promptly to the Board to which it is assigned. In this way all vital activities of the Association can be handled thoroughly and expeditiously. I would also like to urge that each member of the Medical Association give his full cooperation to the activities of the Committees and Boards in order that they may properly and promptly make their reports.

Appointments to the Boards and Committees will appear in the July issue of the *Journal*. Please file this list for easy reference so that you will know how to communicate in reference to your problems.

The reorganization of the committees of MAG provide us with the machinery for improved communications and I hope we will all avail ourselves of this improvement.

President, Medical Association of Georgia



legal page

THE DEFENSE OF INSANITY

John L. Moore, Jr., *Atlanta*

NO MORE DIFFICULT issue in the medical legal field arises to test the mutual understanding of doctors and lawyers than the question of the defense of insanity to a charge of crime. A part of a charge of a Mississippi judge to a jury in a murder case is one example:

"I hold as a matter of law that the only absolute defense of insanity known in the State of Mississippi is paranoia. That is just real, flat insanity, not temporary, so if you are pleading insanity, the only insanity I recognize is paranoia."

The rule followed in most States and in England was laid down in *M'Naghten's Case* in 1843. M'Naghten, apparently suffering from serious paranoia, decided that it was necessary to kill Sir Robert Peel, Prime Minister of England. By mistake he shot the Prime Minister's secretary instead. The law lords were asked to define the defense of insanity in connection with that case and stated that the test is the capacity of the accused to know what he was doing and to know that it was wrong. This test fairly well complied with medical thinking of the time which regarded the brain as compartmentalized and insanity as a complete and irrevocable state.

The definition of mental illness and the recognition of varying degrees of mental illness have both changed enormously since 1843. Increasingly, one finds courts today struggling with an attempt to apply the rule of *M'Naghten's Case* to modern psychiatry. Expert witnesses as to the psychiatric state of the defendant are frequently unable to answer the question asked in any way that is acceptable to the psychiatrist.

In 1954, the United States Court of Appeals for the District of Columbia in the case of *Durham* held that an accused is not criminally responsible if his

unlawful act was the product of mental disease or of a mental defect. There have been many criticisms of the rule of *Durham's* case on the grounds that it leaves such words as "disease" or "defect" and the difficult concept of "product" undefined.

Another alternative is proposed in the American Law Institute Model Penal Code as follows:

"(1) A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law.

"(2) The terms of 'mental disease or defect' do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct."

In May, 1961, this latter rule was adopted by the United States Court of Appeals for the Third Circuit in a modified form. That Court omitted the words "either to appreciate the criminality of his conduct or" from the first step, saying that those words over-emphasized the cognitive element in criminal responsibility.

While the rules discussed in this article may not conform entirely to the best medical opinions today, yet it is believed that the courts, by the constant pressure of trying to fit medical opinion into legal concepts established in long past cases, are gradually narrowing the gap between medical opinion and legal rule. Probably the most difficult block in the way of bringing the two completely together is that the approach of medicine is individual and patient-oriented. The approach of a court, conditioned as it is by responsibility to keep society in general in order, rather emphasizes the danger to society than the individual patient's welfare.

Prepared at the request of the Medical Association of Georgia. Mr. Moore is an associate in the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.



cancer page

CANCER MORTALITY IN GEORGIA

W. J. Murphy, M.D., *Atlanta*

DURING THE TEN YEAR period from 1949 to 1959, the number of cancer deaths in Georgia increased from 3,200 to 4,169. This upward trend paralleled the experience of the nation as a whole and, to a large extent, was the result of an aging population.

The accompanying table compares Georgia's current cancer mortality with that of the United States. Age-adjusted death rates for a number of different types of cancer are shown.

CANCER MORTALITY IN GEORGIA AND THE U.S.
Death Rates per 100,000 Population
1958

	Georgia	U.S.
All Sites	126.0	146.9
Breast (female)	19.2	25.6
Cervix	14.1	9.8
Respiratory system	16.6	20.8
Stomach	9.7	12.1
Rectum	3.2	6.3
Prostate	16.9	16.3
Skin	1.5	1.1
Leukemia	5.8	6.9

The incidence of cancer by site varies considerably in different geographic areas. Some of those variations may be readily explained on the basis of differences in the age or racial composition of the population, the influence of environmental conditions, or other factors. In many instances, however, no satisfactory explanation is apparent.

The death rate from cancer of the cervix in Geor-

gia is significantly higher than the national figure due, primarily, to a greater proportion of colored females in whom the incidence of cervical cancer is far above the rate for white females. Nevertheless, the incidence of cervical cancer among white females in Georgia is also above the corresponding rate for the nation. This might be due, in part, to an economic factor since the disease is observed more commonly among women in the lower income groups.

Deaths from cancer of the skin are not very numerous at the present time and the rates shown in the table do not fully reflect the higher incidence in Georgia. It is well known that skin cancer occurs more commonly in the South due, primarily, to a greater degree of exposure to sunlight. In 1948 a survey conducted in ten American cities by the Public Health Service showed the incidence of skin cancer among white residents of Atlanta to be about four times as great as the rate in Chicago.

On the other hand, the death rate from cancer of the stomach is appreciably lower in Georgia than in the country as a whole. Considering only the white race, the death rate in Georgia is only about one-half the figure for the United States. The colored rate in Georgia is well above the white rate and approximately equal to the non-white rate for the nation.

In general, death rates from gastric cancer in the southern states are well below the recorded figures for the northeastern states. This geographic varia-

tion may be due, in part, to a greater concentration of foreign-born whites in the large metropolitan areas of the Northeast. Recent studies indicate that gastric cancer occurs more commonly among immigrants than among native-born whites. Moreover, since the proportion of foreign-born whites in the United States has been decreasing, this might also be a factor in the declining death rate from gastric cancer.

Approved by Professional Education Committee, Georgia Division, ACS.

The lower death rate in Georgia from cancer of the rectum cannot be explained on the basis of race or nativity. Similarly, racial factors account only in part for the lower death rate from breast cancer. On the other hand, racial differences are largely responsible for the lower death rate from cancer of the respiratory system.

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Fulton County Medical Society, Woman's Auxiliary	Atlanta
Hock, Charles W.	Augusta
Head, D. L., Jr.	Thomaston
Hagood, Murl	Marietta

<i>Name</i>	<i>Address</i>
Jones, John P.	Macon
Lazenby, E. K., Mrs.	Tifton
Medical Association of Georgia, Woman's Auxiliary	Columbus
Mathis, W. H., Jr.	Thomaston
Orr, M.	Marietta
Richmond County Medical Society, Woman's Auxiliary	Augusta
Smaha, Tofey G.	Griffin
Sale, Walter T.	Atlanta
Upson County Medical Society, Woman's Auxiliary	Thomaston
Vassey, George C.	Rossville
Van Sant, T. J., Jr.	Marietta
Whatley, George	Columbus
Walker-Catoosa-Wade Medical Society, Woman's Auxiliary	Ft. Oglethorpe
Worth County Medical Society, Woman's Auxiliary	Sylvester

UNIVERSITY HOSPITAL CAN TAKE MENTAL PATIENTS WITHOUT THEIR CONSENT

UNIVERSITY HOSPITAL, operated by the Richmond County Hospital Authority was recently designated by the State of Georgia as a mental hospital to which patients can be admitted without their consent. Prior to this action by State officials, only the

State institution at Milledgeville had authority to accept patients committed through the courts. The hospital has retained the right to refuse to accept any patient and the approval of the hospital must be obtained before any patient can be committed to it.



PSYCHOGENIC HEART DISEASE

Arthur M. Knight, Jr., M.D., *Waycross*

PATIENTS PRESENTING the entities considered under this label do not usually have organic heart disease but sick personalities. They may also have psychogenic symptoms arising in other systems. Most of such patients are suffering from some type of psychoneurosis.

The patient with an anxiety neurosis suffers from a state of apprehensive tension characterized by a frequently recurring feeling that something bad is going to happen. This often becomes very acute in attacks in which he is aware of such manifestations as sinus tachycardia, premature systoles, hyperpnea, sweating, tremor, and weakness. Because his emotional conflict is on an unconscious level, he is aware only of these somatic symptoms. The effort syndrome is a manifestation of an anxiety state.

Hysteria may also produce cardiovascular symptoms which have some obscure, symbolic and unconscious meaning for the patient. In such cases the "heart disease" serves some useful purpose in the patient's life, such as protecting him from the necessity of meeting his responsibilities.

Tension and fatigue often produce premature contractions and a sense of pressure or of a "load on the chest." Neurotic people often feel weak and blame this on a "weak heart" or on "low blood pressure." Depressed people often feel "bad all over" and sometimes suspect heart disease as the cause. Cardiovascular symptoms in neurotic patients often begin soon after the death from a coronary occlusion of a relative or close friend.

Strong emotions such as anxiety can influence cardiovascular functions profoundly, producing such symptoms as sinus tachycardia, premature systoles,

runs of premature systoles, paroxysmal tachycardia, and even paroxysmal atrial fibrillation. Emotional tension can precipitate attacks of angina pectoris and acute pulmonary edema; it can also elevate blood pressure. Other respiratory symptoms, such as sighing respirations and hyperventilation, are due to emotional influences, and the patient often interprets them as indicating heart disease.

Physicians too often serve as etiologic agents in the production of psychogenic heart disease. The doctor is a trusted and respected authority, and the neurotic patient is often highly suggestible. Therefore, the statements of the doctor are likely to have a profound psychological impact on the thinking of the patient. If the doctor mistakenly states or hints that such a patient has heart disease, the patient is liable to be convinced that this is true. Afterwards, it will be very difficult for anyone to convince him that his heart is normal. For this reason, it is most important for us to choose carefully the words we use in explaining symptoms to patients. For example, it is extremely poor judgment to refer to a paroxysm of tachycardia as a "heart attack."

To tell a patient that he has a "nervous heart" is also poor judgment, because this places the emphasis on the somatic rather than the psychological aspect of the illness. One should try to help the patient to understand that it is his personality which is sick, not his heart.

One should never call the patient's attention to his heart murmurs or to the level of his blood pressure. If the doctor is not certain that a patient has heart disease, he should scrupulously avoid making undesirable suggestions to the patient, and he should

refer him, with much reassurance, to an internist, a cardiologist, or one of the free heart clinics.

The patient with a cardiac neurosis deserves a thorough history, complete physical examination, adequate laboratory studies, a chest x-ray, and an electrocardiogram. This will help convince him that he has been adequately studied and will support the reassurance his doctor gives him. It will also find the occasional neurotic who has organic heart disease as well as functional symptoms.

The doctor who takes time to become acquainted with each patient as a person will find it easy to

recognize psychogenic heart disease by allowing the patient to discuss his family life, business and financial worries, marital difficulties, love life, sexual problems, anxieties, fears, and other emotional symptoms. Such a survey also has considerable psychotherapeutic value. Obstinate or difficult cases should be referred without hesitation to a psychiatrist, but, when this is done, every effort should be made to make the patient understand that it is being done in a sincere spirit of trying to relieve him of his suffering.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

FILM ON CONGENITAL ANOMALIES

THE NATIONAL FOUNDATION is pleased to announce the availability of a new teaching film, THE DIAGNOSIS OF HIDDEN CONGENITAL ANOMALIES.

The film was prepared by Virginia Apgar, M.D., M.P.H., Director, Division of Congenital Malformations, The National Foundation, and L. Stanley James, B.B., (N.Z.), Department of Pediatrics, College of Physicians and Surgeons, Columbia University. It demonstrates to physicians and nurses a

simple method of examination, done in the first few minutes after birth, for the diagnosis of choanal atresia, laryngeal stenosis, tracheoesophageal fistula, intestinal obstruction, rectal atresia, cleft palate, and diaphragmatic hernia.

The film may be obtained free of charge, except for return postage and insurance, by writing the Department of Professional Education. At least three weeks' advance booking is requested.

EGLESTON'S MISS CANDLISH IS HONORED



In honor of Miss Jessie M. Candlish, beloved Administrator of Henrietta Egleston Hospital for two generations, the Auxiliary of Henrietta Egleston Hospital announces the establishment of the Jessie M. Candlish Scholarship Fund for Nursing Education. Three thousand dollars has been contributed by the Auxiliary and friends of Miss Candlish to initiate this fund. It is hoped that future contributions will establish a fund sufficient to provide income adequate to maintain annual expenses for the education of a nurse committed to pediatrics nursing in Egleston Hospital. Presenting to Miss Candlish the resolution passed by the Auxiliary are Mrs. John W. Cherry, President, and Mrs. Clayton E. Rich, outgoing President. Mr. Gilbert McLemore, who recently succeeded Miss Candlish as Administrator, stated "Her professional integrity and commitment to duty have long made Miss Candlish an example of the finest accomplishments in nursing. This scholarship not only honors a great lady but also the nursing profession of which she is an outstanding representative."



heart page

THE USE OF MOLAR SODIUM LACTATE IN CARDIAC ARRHYTHMIAS

Haywood N. Hill, M.D., *Atlanta*

THE TREATMENT OF CARDIAC arrhythmias associated with excessive slowing of the ventricular rate has always been somewhat unsatisfactory. Sympathomimetic drugs, such as epinephrine, Isuprel and ephedrine are usually used in an attempt to increase the ventricular rate but they are often not too successful. Vagolytic drugs, such as atropine, used in an attempt to decrease the degree of block also often fail to achieve the desired result. In consequence, the physician faced with the problem of a failing circulation under such circumstances, whether due to intrinsic cardiac disease, intracardiac surgery, or the effects of hyperpotassemia, has been relatively helpless. This unfortunate situation has been somewhat improved, however, since Bellet and his co-workers reported in 1955 that Molar Sodium Lactate injected intravenously would produce rapid clinical and electrocardiographic improvement in such cases. Since that time, a number of reports have appeared confirming their findings.

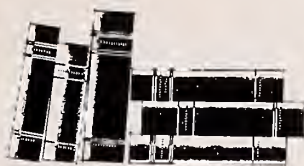
Molar Sodium Lactate seems to be of considerable value in any situation in which the ventricular beat is too slow or too weak to support the circulation adequately. It has been used in cardiac arrest, in ventricular standstill with multiple Stokes-Adams attacks, in complete and partial atrioventricular block, in sinus node suppression, and in cardiotoxicity due to hyperpotassemia. Although the exact correct dosage is not yet known, it is usually given in doses of 20 to 80 c.c. intravenously by syringe over a period of one and a half to two minutes and then, if an effect has been achieved, a drip is set up to give 15 to 20 drops per minute for six to 12 hours. The effects seem to be directly related to the speed

of the infusion. In cases of extreme emergency, with cardiac arrest, Molar Sodium Lactate has been given directly into the ventricular cavity, with very dramatic success. In hyperpotassemia, the electrocardiographic and clinical improvement has occurred rapidly, preceding any change in the potassium level of the serum. The efficacy of maintenance oral doses is now being investigated.

The exact reason for the improvement in ventricular rate, rhythm, and efficiency is not yet known. The possible mechanisms seem to be the beneficial effect of alkalosis on the conducting tissue, the direct utilization of lactate as a fuel by the heart, the increased sodium ion concentration, and the possible vagolytic effect. The first two seem to be most widely accepted. Molar Sodium Lactate has been shown to have no toxic effect in normal hearts in the usual dosages; but, in diseased hearts, premature ventricular beats have been produced and pulmonary edema has occasionally been precipitated or aggravated. These potential toxic effects must therefore be considered and watched for in clinical usage and constant electrocardiographic and bedside observation is essential.

Much investigation remains to be done on this subject and on the whole field of the relationship of electrolyte alterations to cardiac arrhythmias. It certainly seems, however, that every physician now has at hand an agent of great value in combating the emergencies arising from inadequate ventricular rhythms, and that Molar Sodium Lactate now has a definite place in the therapeutic armamentarium of the cardiologist.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.



physician's bookshelf

BOOKS RECEIVED

Yater, Wallace Mason, M.D. and Oliver, William Francis, M.D., *SYMPTOM DIAGNOSIS*, Appleton-Century-Crofts, Inc., New York, N. Y., 1961, 951 pp., diag., tables, \$15.00.

Marti-Ibanez, Felix, M.D., *A PRELUDE TO MEDICAL HISTORY*, M D Publications, Inc., New York, N. Y., 1961, 253 pp., \$5.75.

Risley, Mary, *THE HOUSE OF HEALING*, Doubleday & Company, New York, N. Y., 1961, 288 pp., \$4.50.

Toohy, M., M.D., *MEDICINE FOR NURSES*, Williams & Wilkins Co., Baltimore, Md., 1960, 667 pp., \$7.00.

Phibbs, Brendan, M.D., *THE CARDIAC ARRHYTHMIAS*, The C. V. Mosby Company, St. Louis, 1961, 128 pp., \$7.50.

Francois, Jules, *HEREDITY IN OPHTHALMOLOGY*, The C. V. Mosby Company, St. Louis, 1961, 731 pp., \$23.00.

Sharman, Albert, M.D., *FROM GIRLHOOD TO WOMANHOOD*, Williams & Wilkins Co., Baltimore, Md., 1960, 72 pp., \$1.75.

REVIEWS

Pillsbury, Donald M., M.D.; Shelley, Walter B., M.D.; Klingman, Albert M., M.D.; *A MANUAL OF CUTANEOUS MEDICINE*, W. B. Saunders Company, Philadelphia, Pa., 1961, 393 pp.

THIS SMALL, EXCELLENT, and handy volume is, in essence a condensation of the textbook on dermatology by the same authors which was first published in 1956. Although any attempt at a condensation of essential medical or scientific knowledge is often full of many difficulties and disappointments to the student, nevertheless, in this volume the authors have performed a very fine job.

Since facts, formulary, and opinions which relate to the several specialties of medicine and surgery have become almost overwhelming in their quantity, in this treatise on cutaneous medicine the authors have skillfully summarized and condensed the useful facts regarding the diagnosis, prevention, and care of diseases affecting the skin. The authors have retained the paraphrasing, so useful in the larger volume, and have added diagrams of disease distribution which make this a fine diagnostic textbook—especially is this true in the discussion of distribution patterns of skin diseases. The addition of the outline of the use of the steroids in dermatology, the newer use of the antibiotic preparations, and the treatment of fungus infection with griseofulvin are very welcome additions.

Since this smaller volume must of necessity leave out

the details and opinions of others it is not as valuable for the student of dermatology as for the general medical practitioner, and in some instances may be over-weighted by dogmatic opinions of therapy. Although there is a lack of a large enough bibliography and references, this is excusable in so condensed a text.

The general excellence of this volume as a manual of dermatology, the clarity of its print, good appearance of the photographs, the placing of the diagrams, and the simplicity of the presentation make this textbook a "must" as a desk volume for all general practitioners, surgeons, and interns. One can do nothing less than highly recommend it. I am quite sure that the "colt will outrun its sire."

Herbert S. Alden, M.D.

Peddie, George H., M.D. and Brush, Frances E., R.N., *CARDIO-VASCULAR SURGERY*, G. P. Putnam's Sons, New York, N. Y., 1961, 170 pp., \$2.75.

THE REVIEW OF the book consists of the following statements: In the brief span of several years advances in cardio-vascular surgery have forced responsibilities on many related areas including the nursing profession.

These advances have led to a creation of a whole new specialty in nursing and in nursing education. This Manual should be of value to nurses in cardio-vascular surgery because it emphasizes the importance of attention to the many duties imposed upon them in the overall care of patients. Emphasis has been placed on the medical-surgical aspects of cardio-vascular surgery.

The manual discusses step by step the anatomy, physiology, pathology, diagnostic tests, anesthesia and pre-operative and post-operative care of the cardio-vascular surgical patient. The anatomical situation and the surgical procedures are nicely outlined and the nursing care of these procedures, as well as general thoracic surgical procedures, is explained. Much of the material is presented with specific direction, information and even diagrammatic detail is pursued.

The equipment which is used is described, its care and maintenance explained as well as its physiological effects on the patient.

I do feel that in the realm of artificial ventilation and cardiac arrest, the manual is behind times but it probably was initially drafted prior to the advent of closed

PHYSICIAN'S BOOKSHELF / *continued*

chest cardiac resuscitation and of mouth to mouth resuscitation.

I do feel that the Manual is of tremendous value to all student nurses and may certainly be of help to some medical students.

William C. Wansker, M.D.

Manhold, John H., M.D. and Bolden, Theodore E., M.D., OUTLINE OF PATHOLOGY, W. B. Saunders Company, Philadelphia, 1960, 340 pp.

THIS BOOK CONSISTS OF 340 pages including index. It is printed on glossy paper and is easily readable.

It is arranged essentially in an outline form without illustrations. Most of the information is presented as succinct definitions or statements. It is much more abbreviated than, for example, *A Synopsis of Pathology*, by W. A. D. Anderson.

It might be used by paramedical personnel and Dentists as a quick reference for terms and definitions.

John T. Godwin, M.D.

Rushmer, Robert F., M.D., CARDIOVASCULAR DYNAMICS, W. B. Saunders Co., Philadelphia, Pa., 1961, 503 pp., \$12.50.

THIS BOOK PROVIDES a physiologic basis for the under-

standing of cardiovascular disease. It is written by a physiologist for students of cardiovascular disease, from medical students to specialists in internal medicine and cardiology. The material presented is well organized and easy to read. Especially helpful are the illustrations which are simple, clear and informative.

Certain chapters are devoted primarily to the physiology of the cardiovascular system, while others emphasize items in the physical diagnosis of cardiovascular diseases; still other chapters deal with subjects of more direct interest to the clinician. However, the underlying theme throughout this book is the emphasis placed on the understanding of physiologic principles and the application of these principles to disorders of the cardiovascular system.

Especially interesting was the chapter devoted to the circulatory physiology of changes in posture. Its direct clinical application to postural hypotension is discussed. One chapter is devoted to the circulation of the heart muscle, including the distribution of the coronary arteries. Myocardial ischemia and infarction are discussed in relation to the coronary circulation. The chapter on the embryologic development of the heart helps clarify the anatomic genesis and circulatory physiology and various forms of congenital heart disease.

Charles B. Upshaw, Jr., M.D.

TRIBUTE PAID TO DR. COOK

THE ROTARY CLUB of Macon, through its weekly publication, *Rotary Throbs*, has paid a double tribute to Dr. Ellison R. Cook, III, young Savannah internist who addressed the club on Feb. 13 and was killed in a highway accident the next day.

Two items concerning Dr. Cook, Savannah's Man of the Year in 1950 and Georgia Heart Association president in 1954, appeared in the same issue. The first, written prior to his death, said, in part:

"We witnessed last Monday a great moment in medicine. That profession has produced a man who speaks without effort to seem profound. Dr. Ellison R. Cook, III, has devoted himself to bringing stroke victims back to a normal life.

"His concern is more human than scientific; it even extends to the plight of the victim's family who become, as he says, slaves to the invalid. Who could not admire a man with such a splendid sense of humor and of such courage to have 12 children."

On the front page was the following, written after the fatal accident:

"Macon Rotarians were shocked today by the news of the death of Dr. Ellison R. Cook of Savannah in an automobile accident. Dr. Cook was the speaker at Rotary's luncheon on Monday of this week, when he discussed his specialty—Rehabilitation of Stroke Cases.

"While still a young man he had spent the whole of his professional career in the study of diseases of the heart and their management. Due to his leadership in this field, Georgia ranked at the top in this service to humanity. In memory of him an additional gift to the Heart Fund would seem to be appropriate."

Dr. Cook, a specialist in internal medicine, was born in Newnan and was a graduate of Newnan High School. He received his B.S. and M.D. degrees from Emory University and interned at Charity Hospital in New

Orleans.

During World War II he served as a captain in the U. S. Medical Corps in the European Theater. He later completed additional postgraduate work at Tulane University, where he was awarded a fellowship in internal medicine. He was a diplomate of the American Board of Internal Medicine.

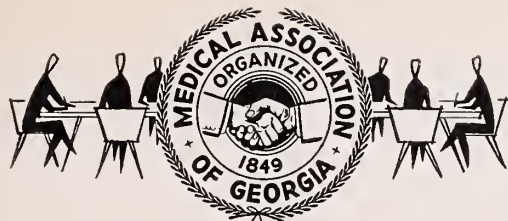
After moving to Savannah, Dr. Cook became very active in medical, religious, civic, political, and youth work. He was founder of the Savannah Stroke Clinic, Savannah Heart Clinic, and one of the directors of the Chatham Clinic for Alcoholism.

He served as president of the Chatham-Savannah Health Council and was active in the programs of the Georgia Heart Association, American Heart Association, Red Cross, Cancer Society, Mental Health Society, and others. He was a steward in Trinity Methodist Church, former general superintendent of the church school, former president of the Men's Club, and had served as president of the Methodist Men of Savannah.

Dr. Cook had served Savannah as an alderman, mayor pro-tem, and as campaign chairman for the Citizens Committee in several elections, including the 1960 ticket. He was Savannah's "Outstanding Young Man of the year" in 1950; was recipient of the Silver Beaver Award, Boy Scouts of America; was a Fellow in the American College of Physicians, and a member of numerous medical societies and fraternities.

Dr. Cook, the father of 12 children, was one of the best known physician-speakers in the state and participated in numerous stroke rehabilitation and education programs on the local, state, and regional levels.

He was killed Tuesday night, February 14, 1961, in an auto accident on U. S. Highway 80 near Savannah. Funeral services were held in Savannah, Friday, February 17, 1961.



the association

DEATHS

MONTE PRESTON AGEE, 61, died in his home in Augusta after a brief illness on May 26, 1961.

A native of Augusta, Dr. Agee was honored last March at a Doctor's Day banquet for his unselfish service to mankind. He graduated from Medical School in 1921.

He was an active member and leader of the Georgia Masonic circles. He was also a member of the Augusta Optimist Club, the Medical Association of Georgia, the Richmond County Medical Society, and the First Baptist Church.

He is survived by his wife, Mrs. Vera Hamilton Agee of Augusta; three daughters, Mrs. C. A. White and Miss Betty Agee, both of Augusta, and Mrs. Wendall Carpenter of Pensacola, Fla.; two sons, Monte Preston Agee, Jr. of North Augusta and William G. Agee of Atlanta; two sisters, Mrs. Henry T. Jones and Miss Edna Agee, both of Augusta; and six grandchildren.

LEON DOUGLAS PORCH of Macon died at the age of 56 on May 25, 1961. He had been ill for two months.

A native of Monroe County, Dr. Porch practiced medicine in Macon until five years ago when he was forced to retire due to bad health. He was educated in the Monroe County public schools and was a graduate of Emory University Medical School.

He was a member of the Macon Lodge 5 of Free and Accepted Masons, Macon Elks Lodge, Joseph N. Neel Post 3 of American Legion, the Bibb County Medical Society, the American Medical Association, and the Medical Association of Georgia. He was a veteran of World War II and a member of Vineville Methodist Church.

Survivors include his wife, the former Miss Clara Dunn, a daughter, Miss Mary J. Porch of Macon, and his mother, Mrs. U. L. Porch of Forsyth.

SOCIETIES

The CAMDEN-CHARLTON COUNTY MEDICAL SOCIETY held its regular monthly meeting in Folkston on May 1. The scientific session was headed by Neal Yeomans of Waycross, with the "Interpretation of X-rays" as the main topic.

The CRAWFORD W. LONG MEDICAL SOCIETY is answering letters addressed to the *Athens Banner-Herald* about medical questions and comments.

The DEKALB COUNTY MEDICAL SOCIETY awarded their annual 300 dollar Nursing Scholarship at a banquet on May 18, to Miss Doris Nell Strange of Avondale High School.

Dr. Francis H. Watt of Tallahassee spoke to the DOUGHERTY COUNTY MEDICAL SOCIETY recently at their regular monthly meeting about methods of low body temperature therapy as developed at Johns Hopkins Hospital and elsewhere.

The FLOYD COUNTY MEDICAL SOCIETY heard a lecture recently on Pelvic Pain by Fred Zuspan.

The FULTON COUNTY MEDICAL SOCIETY was a co-sponsor of a "Physicians' Seminar on American Strategy" held June 3, at the First Baptist Church in Atlanta. It is a part of Project Alert which was organized recently to present "to all citizens a clear view of the Communist challenge."

The FRANKLIN COUNTY MEDICAL SOCIETY met on June 7, 1961 at the Nancy Hart Hotel in Hartwell.

The GEORGIA MEDICAL SOCIETY had a program on June 13 at the DeSoto Hotel with Mr. Calvin D. Johnson speaking on "American Heritage and Our Children's Future."

The HABERSHAM COUNTY MEDICAL SOCIETY had Dr. Richard Torpin as their guest speaker on May 15 when they met at Tate's Restaurant.

The OCMULGEE COUNTY MEDICAL SOCIETY met on June 13, 1961 and discussed the meetings and projects suggested at the Annual Session of this year.

The BIBB COUNTY MEDICAL SOCIETY had a meeting with the coaches and trainers of the Little Leaguers in Macon. They discussed ways that the rate of head injuries could be cut down.

The RICHMOND COUNTY MEDICAL SOCIETY has continued their panel discussions open to the public in Augusta. Two of the topics discussed recently were Cancer and Menopause.

The SOUTHWEST GEORGIA MEDICAL SOCIETY met the last of May and had A. M. Freeman of

Albany speak on "More Common Epiphysical Disorders."

The SUMTER COUNTY MEDICAL SOCIETY elected Harold Clayton their president. At the same meeting they saw a film on "Problems of the Aged."

The THOMAS-BROOKS MEDICAL ASSOCIATION held their quarterly meeting at the Archbold Memorial Hospital. Their guest was Dr. William R. Hancock of Jacksonville, Florida, who spoke on "Gastroenterology."

The TIFT COUNTY MEDICAL SOCIETY had Bruce Logue speak to them recently on "Management of Myocardial Infarction."

The WARE COUNTY MEDICAL SOCIETY met in the middle of May and had a film on a new drug from Armour Laboratories.

PERSONALS

First District

MELVIN BERLIN was named vice president of the board of trustees of the Chatham-Savannah Health Council in May.

W. W. AIKEN and J. D. McARTHUR opened their new offices in Toombs County on June 15.

L. H. GRIFFIN of Claxton was installed as President of the Alumni of the Medical College of Georgia at the annual banquet held at the Piedmont Driving Club in Atlanta.

Four Savannah doctors, J. BRUCE SAMS, JR., JOHN L. ELLIOTT, MASON G. ROBERTSON, and JULIAN K. QUATTLEBAUM, JR., were panelists on the subject of heart problems on May 8. J. GORDON BARROW was the forum's principal speaker.

Second District

Y. F. CARTER of Nashville was the principal speaker recently at the 13th District of the Georgia Association of Licensed Practical Nurses, Inc.

Third District

W. G. ELLIOTT, Cuthbert, was elected president of the Georgia Chapter, American College of Chest Physicians.

Fourth District

THOMAS BROWNE, a native of Upson County, is moving to Atlanta to continue his practice. His replacement will be B. B. BARMORE, JR.

JAMES W. PURCELL of Covington has been named a member of the International College of Surgeons at their convocation in Chicago.

LaGrange's ENOCH CALLAWAY recently delivered a lecture to the Hogansville Kiwanians.

Fifth District

DOROTHY S. JAEGER-LEE opened her new offices on Piedmont Road in Atlanta last month. Her practice will be limited to pediatrics.

A. H. LETTON, Atlanta, attended a meeting of Region III, American Cancer Society at Williamsburg, Va. in May. During this meeting Dr. Letton was elected chairman of Region III, which includes all of the Southeastern states.

JOHN T. LESLIE of Decatur has been named president of the Georgia Pediatric Society and JOSEPH PATTERSON of Atlanta, president-elect.

SIDNEY ISENBERG of Atlanta delivered a lecture at the Lenwood Division of the VA Hospital in Augusta in May.

Sixth District

JAMES A. JOHNSON, JR. spoke at the Seminar Program of the Students-Faculty-Alumni Day of the School of Pharmacy at the University of Georgia in the latter part of May.

Seventh District

PETE INGLIS of Marietta was recently named president of the Cobb-Douglas-Paulding Tuberculosis Association.

DAVID NOWELL returned home recently from Miami Beach where he and Mrs. Nowell attended the annual meeting of the American College of Obstetrics and Gynecology.

ALFRED COLQUITT, JR., Marietta, has been elected a member of the board of directors of Cobb Exchange Bank.

A. RICHARD GRAY of Rome has been elected a lieutenant governor of Optimist Club International. He was elected at the 14th annual District Convention of Optimist International held at Radium Springs.

Eighth District

ARTHUR M. KNIGHT and JAMES O. SIMMONS spent the month of June at Harvard University Medical School where they took a course in Internal Medicine.

NEAL YEOMANS of Waycross spoke to the Waycross Kiwanians about the seven danger signs of cancer at the end of May.

J. L. HUNT of Brunswick has moved his office to 206 Dunwoody Building in the same city.

W. G. TRAMBLE has accepted a position on the West Coast.

Ninth District

GRADY N. COKER of Canton was given special recognition at an Appreciation Day dinner in a joint meeting of members of Canton Kiwanis, Lions and Rotary Clubs.

BRUCE SHAEFFER of Toccoa was one of the men who attended the Formation of an Association of University Residents of Johns Hopkins University and the University of Maryland which was held the latter part of April.

Tenth District

TOM A. DOVER of Athens has been elected to the position of president-elect of the Georgia State Obstetrical and Gynecological Society at their annual in May.

THOMAS GOODWIN of Augusta spoke against socialized medicine on the federal level at a meeting of the Augusta Pharmaceutical Association in May.

GEORGE H. ALEXANDER attended a meeting in Indianapolis, Ind. in June sponsored by the Eli Lilly Company.

ANNOUNCEMENTS

The Department of Internal Medicine of Emory University School of Medicine will present a postgraduate course entitled "Five Days of Internal Medicine," Monday through Friday, September 25-29, 1961. Fee: \$80.00. For further information write: J. Willis Hurst, M.D., Department of Medicine, Emory University School of Medicine, 69 Butler Street, S.E., Atlanta 3, Georgia.

The American College of Gastroenterology announces that its Annual Course in Postgraduate Gastroenterology will be given at the Sheraton-Cleveland in Cleveland, Ohio, on October 26-28, 1961. For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

1961-62 ORGANIZATION MEETING OF THE COUNCIL OF THE MEDICAL ASSOCIATION OF GEORGIA

THE 1961-62 ORGANIZATIONAL meeting of the Council of the Medical Association of Georgia was called to order by President Fred Simonton, Chickamauga, at 12:00 noon, May 10, 1961, in the Main Meeting Room, Biltmore Hotel, Atlanta, Georgia.

Present in addition to President Fred Simonton were: President-Elect Thomas W. Goodwin, Augusta; Immediate Past President Milford B. Hatcher, Macon; First Vice President Linton H. Bishop, Atlanta; Secretary John T. Mauldin, Atlanta; Speaker of the House J. Frank Walker, Atlanta; Councilors: T. A. Peterson, Savannah, Georgia Medical Society, Vice Councilor; Walter Brown, Savannah, Georgia Medical Society; George R. Dillinger, Thomasville, 2nd District; Frank Wilson, Leslie, 3rd District; Virgil Williams, Griffin, 4th District; C. T. Cowart, LaGrange, Vice Councilor 4th District; Floyd R. Sanders, Decatur, 5th District; J. G. McDaniel, Atlanta, Fulton County Medical Society; George H. Alexander, Forsyth, Bibb County Medical Society; Ralph W. Fowler, Marietta, 7th District; F. G. Eldridge, Valdosta, 8th District; C. R. Andrews, Canton, 9th District; Paul T. Scoggins, Commerce, 9th District Vice Councilor; Addison W. Simpson, Washington, 10th District; W. P. Jordan, Columbus, Muscogee County Medical Society; H. D. Pinson, Augusta, Richmond County Medical Society; J. L. Mulherin, Augusta, Richmond County Medical Society Vice Councilor; AMA Delegates: Eustace A. Allen, Atlanta; J. W. Chambers, LaGrange; and Henry H. Tift, Macon. MAG staff present were: Mr. M. D. Krueger, Executive Secretary; Mr. James M. Moffett, Assistant Executive Secretary; and Mrs. Catherine Wooten, Executive Assistant.

Welcome to New Councilors

President Simonton welcomed the new Councilors and Officers to the first Organizational Meeting of Council for 1961-62.

Nomination and Election of Council Chairman and Vice Chairman for 1961-62

On motion (Simpson-Williams) it was voted to elect George H. Alexander, Bibb County Medical Society Councilor, Chairman of Council for the year 1961-62.

Chairman Alexander thanked the Council for electing him to

this position and then called for nominations for Vice Chairman of Council. On motion (Dillinger-Goodwin) it was voted to elect Virgil Williams, Griffin, Fourth District Councilor, as Vice Chairman of Council for the year 1961-62.

Council Appointment of Editor, MAG Journal

Chairman Alexander called for the appointment of an Editor of the Journal of the MAG for the year 1961-62, and on motion duly made and seconded it was voted to reappoint Edgar Woody, Jr., Atlanta, as Editor of the JMAG.

Appointment of Council Finance Committee by Council Chairman

Chairman Alexander appointed J. G. McDaniel, Chairman of the Finance Committee, with Virgil Williams, Griffin, and C. R. Andrews, Canton, as members of this Committee.

At this time Chairman Alexander called for a five minute recess of the Council meeting.

EXECUTIVE COMMITTEE OF COUNCIL ORGANIZATIONAL MEETING

THE CHAIRMAN of the Executive Committee of Council Fred Simonton, President, called the Executive Committee of Council to order at 12:05 P.M., in the Main Meeting Room, Biltmore Hotel, Atlanta, Georgia, on May 10, 1961.

Members of the Executive Committee present included: Fred Simonton, Chickamauga, President and Chairman; Thomas W. Goodwin, Augusta, President-Elect; Milford B. Hatcher, Macon, Immediate Past President; John T. Mauldin, Atlanta, Secretary; George H. Alexander, Forsyth, Chairman of Council; and J. G. McDaniel, Atlanta, Chairman of Finance. Also present was Mr. M. D. Krueger, Executive Secretary.

Appointment of Treasurer for 1961-62

By general agreement it was recommended that C. Raymond Arp, Atlanta, be reappointed Association Treasurer for 1961-62.

Selection of Executive Secretary for 1961-62

By general agreement it was recommended that Mr. Milton D. Krueger be reappointed Executive Secretary of the Medical Association of Georgia for 1961-62.

Date and Site of June Executive Committee of Council Meeting

By general agreement, it was recommended that the Executive Committee meet at the same time as Council in June 1961.

There being no further business the Executive Committee of Council meeting was adjourned at 12:10 P.M.

RECONVENED ORGANIZATIONAL MEETING OF COUNCIL

CHAIRMAN ALEXANDER called the reconvened organizational meeting of the Council of the Medical Association of Georgia to order at 12:10 P.M., May 10, 1961, in the Main Meeting Room, Biltmore Hotel, Atlanta, Georgia.

Council Action on Executive Committee Recommendations

On motion duly made and seconded the previous action of the Executive Committee of Council on the appointment of C. Raymond Arp, Atlanta, as Treasurer for 1961-62; and the selection of the Executive Secretary, Mr. Milton D. Krueger, was approved.

New Business

(a) George R. Dillinger, Thomasville, asked for a good delegation to the AMA Annual Session in June, and asked for approval for attendance at this meeting by Mr. Krueger and Mr. Moffett. On motion (Dillinger-Walker) it was voted to approve sending Mr. Moffett to the AMA meeting, in addition to Mr. Krueger.

(b) Mr. Moffett asked for appointment of a replacement for John K. Davidson, Columbus, on the Interprofessional Council.

On motion (Hatcher-Simpson) it was voted to have the President make the appointment.

(c) Date and site of the next Council meeting: On motion (Hatcher-Fowler) it was voted to leave the decision to the Chairman of Council. Chairman Alexander chose June 11, 1961, Atlanta, as the date and site. The Executive meeting time will be decided at a later date.

There being no further business the meeting was adjourned at 12:20 P.M.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING

THE MAY MEETING of the MAG Council was called to order by Vice Chairman Virgil Williams at 7:40 P.M., in the absence of Chairman McDaniel, at the Biltmore Hotel, May 6, 1961, Atlanta, Georgia.

The members of Council present were: Milford B. Hatcher, President; Fred H. Simonton, Chickamauga, President-Elect; Luther H. Wolff, Columbus, Immediate Past President; Braswell E. Collins, Macon, Second Vice President; John T. Mauldin, Atlanta, Secretary; C. Raymond Arp, Atlanta, Treasurer; Thomas W. Goodwin, Augusta, Speaker of the House; J. G. McDaniel, Atlanta, Chairman; George R. Dillinger, Thomasville, 2nd District; W. G. Elliott, Cuthbert, 3rd District; Virgil Williams, Griffin, 4th District; George H. Alexander, Forsyth, 6th District; F. G. Eldridge, Valdosta, 8th District; C. R. Andrews, Canton, 9th District; Addison Simpson, Jr., Washington, 10th District; T. A. Peterson, Savannah, 1st District Vice Councilor; Paul T. Scoggins, Commerce, 9th District Vice Councilor; M. A. Hubert, Athens, 10th District; Edgar Woody, Jr., Atlanta, Editor; AMA Delegates: Eustace A. Allen, Atlanta; J. W. Chambers, LaGrange; and Henry H. Tift, Macon. Also present were Mr. John Moore, MAG Attorney; Mr. Frank Lipsey, Medicare Administrator; Mr. Milton D. Krueger, Executive Secretary; Mr. James M. Moffett, Assistant Executive Secretary; and Mrs. Catherine Wooten, Executive Assistant.

Mr. Krueger read the minutes of the last Council meeting on April 25-26, 1961. On motion (Simonton-Simpson) it was voted to amend the minutes under the heading of "Meriwether-Harris County Society Problem" as follows: "Mr. Shackelford stated that there would be a legal fee ranging between \$2500-\$3500 for trying this case and an additional fee between \$1500 and \$2500 if the case were taken to the Appellate Court or Courts." The Executive Committee minutes of March 26 and April 22, 1961 were also read. On motion duly made and seconded these minutes were approved as read.

Chairman McDaniel took the gavel at this point and the meeting continued.

Committee Appointment

It was suggested that A. M. Phillips, Macon, be added to the Insurance and Economics Committee. On motion (Collins-Andrews) it was voted to add Mr. Phillips's name to the committee.

Relative Value Study Committee Report

Mr. Lipsey gave this report for Chairman Pinson, who could not be present. It was recommended that at the organizational meeting an AMA representative be present to inform the members of the committee. The committee recommended that the study be continued, and that the committee formulate a schedule of relative values for the state of Georgia. The committee requested that funds be made available (\$300.00 for the first year) to carry out this work which probably will extend over a period of two or three years. On motion (Hatcher-Alexander) it was voted to approve continuation of the study. On motion (Mauldin-Simonton) it was voted to inform the committee that the budget is already set up for the coming year and if funds are needed the committee should make a special request for such.

Physical Therapy Practice Act

There was general discussion of the Act. On motion (Hatcher-Williams) it was voted to endorse the formulation of a board with the recommendation that at least two physicians be on the board and that it be under the supervision of the Board of Medical Examiners. It was recommended that this be referred to the Legislative Committee with instructions to appoint these two physicians.

Financial Statement

Treasurer Arp gave this report for information. On motion duly made and seconded it was voted to approve this report as read.

Duplicate Bridge Tournament

Chairman McDaniel asked for consideration by Council of the payment of one-half the cost of the Tournament at the Annual Session, with the other half to be paid by Fulton County Medical Society. On motion (Peterson-Simpson) it was voted that the Annual Session Committee underwrite the expense for this Tournament.

Georgia Podiatry Association Request

Chairman McDaniel, at request of Council, appointed three physicians to assist the Georgia Podiatry Association in changing the Blue Shield Act. These appointments are as follows: Luther H. Wolff, Columbus, Chairman; L. G. Bayne, Atlanta, and L. H. Hamff, Atlanta. On motion duly made and seconded it was voted to accept these appointments as made by Dr. McDaniel with instructions to the Executive Secretary to notify these doctors.

Directory of Paramedical Service for the Disabled

Chairman McDaniel read a letter from Jack Hughston, Columbus, regarding endorsement of this directory. On motion (Hatcher-Paterson) it was voted to instruct Dr. Hughston to meet with Robert L. Bennett, Warm Springs, for coordination with a similar project which Dr. Bennett has underway, and to inform Dr. Hughston that MAG approves the publishing of this directory.

Annual Session Orientation

Dr. Tift and Mr. Krueger gave instructions regarding the Annual Session Business Sessions, House of Delegates, Reference Committees, etc.

Unfinished Business

(a) *Crawford Long Memorial*: Dr. Scoggins discussed the closing of the Memorial due to lack of funds. On motion duly made and seconded it was voted that MAG not participate until such time as approached by the County Medical Society and local townspeople.

New Business

(a) Braswell Collins, Macon, expressed appreciation for his year's association with Council as Second Vice President.

(b) *Managing Editor, JMAG Replacement*: Editor Edgar Woody stated that Mrs. Anne Kirkland's position had been filled by the employment of Miss Virginia Gaines. On motion (Hatcher-Simonton) the employment of Miss Gaines was approved.

(c) *Elliott Resolution*: Dr. J. W. Chambers asked Council to draft a Resolution commending W. G. Elliott for his years of service on the Council.

(d) There was discussion of the Meriwether-Harris County Medical Society problem.

AMA Resolution

Delegate Eustace A. Allen asked that the three AMA delegates be authorized to introduce a resolution commending AMA. On motion duly made and seconded it was so approved.

Chairman McDaniel tendered his resignation as Chairman of Council and thanked the Council members for their cooperation and efforts during his term as Chairman.

There being no further business the meeting was adjourned at 9:30 P.M.

Medical

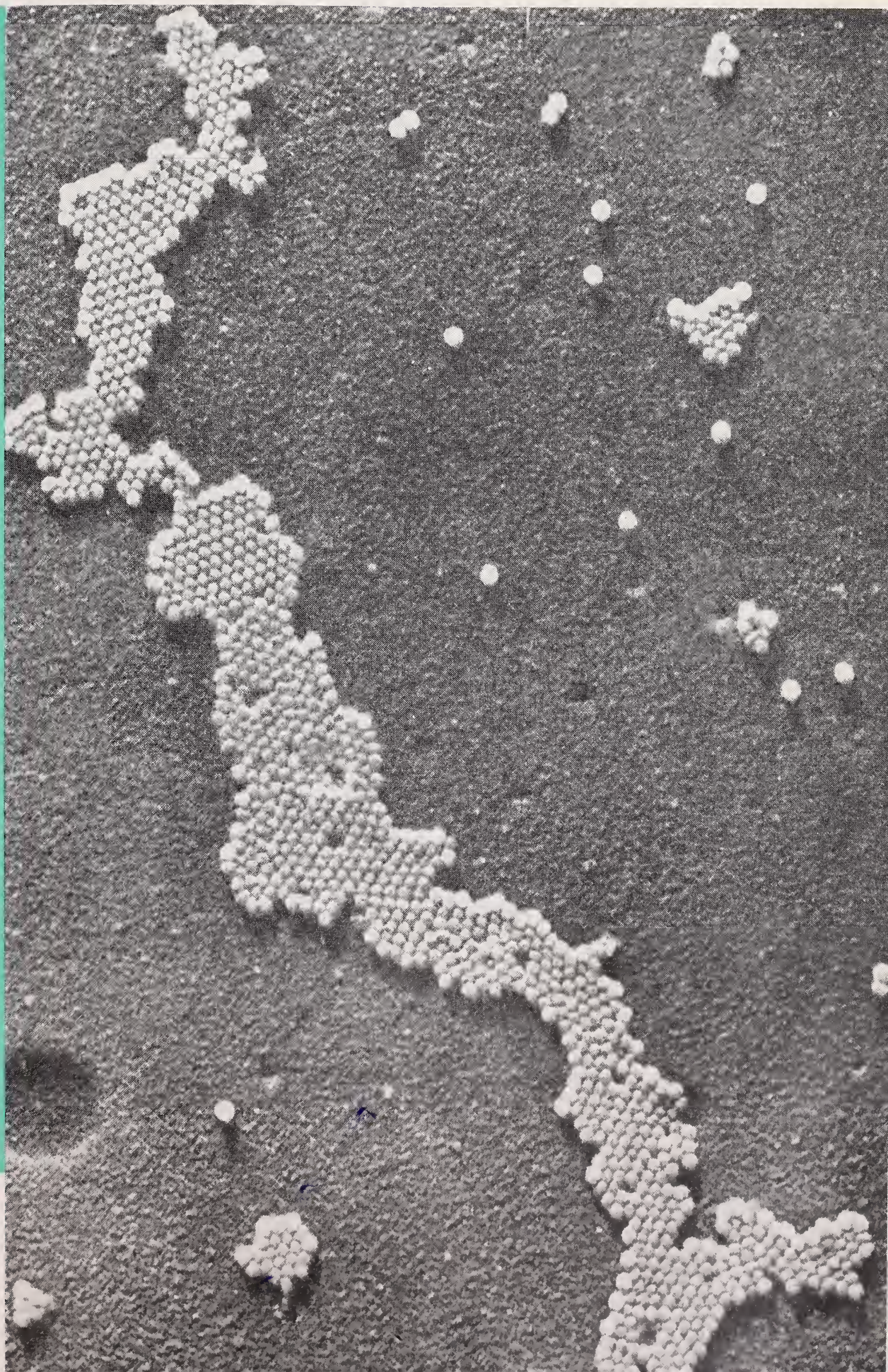
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PHEOCHROMOCYTOMA IN A CHILD

Dan Burge, M.D.; William G. Whitaker, M.D., *Atlanta*

Only about one per cent of all pheochromocytomas occur in the first decade of life.

ON JULY 12, 1957 a six year old colored boy was admitted to the Hughes Spalding Pavilion of Grady Memorial Hospital. The mother stated that the child had experienced recurrent retrosternal, non-pleuritic, chest pain, frequent profuse sweats, and steady weight loss since early in May 1957. He had had no chills and his temperature had never been found to be elevated during this illness. During a period of three or four weeks prior to admission, dyspnea at rest, orthopnea, nausea and vomiting had developed.

No history of pain, stiffness or swelling of the joints was obtained. No throat infections were recognized during or preceding this illness. There was no history suggestive of hematuria. During the summer of 1956 a left inguinal abscess had been incised and drained. Otherwise the patient had been well prior to the present illness.

Physical examination: Temperature 99.5 by rectum, pulse 130 (sinus tachycardia), respirations were 22 per minute and somewhat deeper than normal. Blood pressure was 160/140 in both arms and 200/120 in the left upper extremity. Femoral pulses were strong and bilaterally equal. The patient was quite thin. He appeared weak and listless. His skin was warm and wet with perspiration. No petechiae were noted. The fundal arterioles were rather tortuous, but there was normal AV ratio and no hemorrhages or exudates were seen. The thyroid gland was not enlarged. Small firm discrete lymph nodes were felt in the neck, both axillae and in the groins. No precordial bulge was noted, but the precordium was quite active. The heart was enlarged to the left anterior axillary line and extended two cm

to the right of the sternum in the 4th intercostal space. A grade III systolic murmur was heard loudest at the apex. The aortic second sound was more intense than the pulmonic second sound. A diastolic gallop rhythm was noted. A few moist rales were heard at the lung bases. The liver was felt two finger breadths below the right costal margin in the mid-clavicular line, and the spleen was not palpable. An electrocardiogram showed only sinus tachycardia. Chest x-rays (figure 1) and fluoroscopy confirmed generalized cardiac enlargement and pulmonary congestion. The left atrium was not disproportionately enlarged. No abnormal pulsations of the pulmonary vessels could be seen fluoroscopically.



Figure 1

PHEOCHROMOCYTOMA / continued

On admission his hemoglobin was 15.4 grams, packed cell volume 50 per cent, WBC 12,100 with 6 eosinophiles, 53 segmenters, 42 lymphocytes, and erythrocyte sedimentation rate was 21 mm an hour. Urinalysis: pH 5.5, sp. gr. 1.010, albumin 3 plus, sugar negative, 3-5 wbc, 2-4 rbc, with a few hyalin casts. On July 13, 1957 blood urea nitrogen was 24 mg. per cent and on July 15, 1957 was 18 mg. per cent. On admission, fasting blood sugar was 94 mg. per cent. Sick cell preparations were negative immediately and after 24 hours. Phelnolsulfonphthalein test on July 13, 1957: five per cent in 15 minutes, 15 per cent in 30 minutes, 20 per cent in 60 minutes with a total excretion of 40 per cent in one hour. The V.D.R.L. was negative. Repeat urinalysis on July 15, 1957 showed a specific gravity of 1.010, two plus albumin and negative sugar and 10 to 12 wbc per high powered field. Urine culture was negative. Five blood cultures obtained during the first two days in the hospital were sterile. An intravenous pyelogram was normal. Diagnosis on admission was congestive heart failure, probably secondary to hypertension. The severe hypertension was thought to be due to a pheochromocytoma and/or chronic renal disease.

Hospital course: During the two weeks following admission the patient's blood pressure rather steadily climbed to a high of 230/190. One reading of 210/190 was obtained. The patient's dyspnea, weakness, basal rales and hepatomegaly responded to low sodium diet, digitalis, and several injections of a mercurial diuretic. During this same two week interval, four Regitine* tests were performed, three intravenous and one intramuscular. The first three of these showed diastolic pressure falls in excess of 30 mm of mercury, and systolic falls of 20 to 25 mm of mercury. A fourth test using two mgm Regitine intravenously resulted in a systolic pressure fall of 54 mm (180 to 126), and a diastolic fall of 64 mm (164 to 100). Catecholamine excretion was reported as 50 mcgm per cent. The 25-hour volume was not reported. The last Regitine test seemed to establish the diagnosis of a chromaffin tumor.

On July 26, 1957 the patient was started on Regitine every four hours by mouth, in doses from 25 to 75 mgm each, usually 50 mgm. This resulted in maintenance of blood pressure between 100/80 and 190/100 for one week prior to surgery. 140/90 was frequently recorded. After receiving Regitine 2.5 mgm. intravenously and 2.5 mgm intramuscularly, the patient entered the operating room on August 2, 1957 with a blood pressure of a 140/100. During surgery his blood pressure was checked once per

minute. Regitine 2.5 mgm was given intravenously four times during the first 45 minutes of surgery, whenever the diastolic pressure exceeded 120.

Preoperative planning and preparation for these patients differ considerably from those of the usual abdominal procedure. Obviously, anemia and metabolic disturbances should be corrected prior to operation. A venous cutdown with insertion of an adequate polyethylene catheter, particularly in children, allows prompt administration of fluids, blood and pressure regulating drugs. A titration arrangement using a Y tube will allow administration alternately of vasopressor and adrenolytic agents during the operative procedure. The titration with these materials is usually in charge of the anesthesiologist and the internist who monitor the cardiovascular responses of the patient during the conduct of the operation. A supply of adrenocortical steroids, Epinephrin and Neosynephrin, should be immediately available. Norepinephrine and Regitine solutions are effective agents and are the drugs most often used. General anesthesia administered by an endotracheal system is advocated. Anesthetic agents, such as Cyclopropane, which increase cardiac irritability in the presence of vasopressor drugs should not be used. It is generally accepted that transabdominal approach for excision of pheochromocytoma is superior to other routes. A generous supra-umbilical transverse incision allows exploration of both adrenal areas as well as the paraganglionic regions. This is particularly important since often the laterality of the suspected tumor is unknown. Furthermore, the need for questionable and perhaps dangerous insufflation studies is eliminated. When the abdominal cavity is entered manual exploration usually will reveal the site of origin of the tumor and lead the operator directly to the site. The adrenal gland may be approached via an avascular area, in the transverse mesocolon, by division of the gastrocolic ligament, or reflection of the splenic flexure and descending colon medialward after incising the peritoneum of the lateral gutter. On the right side, mobilization of the hepatic flexure and duodenum allows access to the kidney and adrenal gland. When the tumor lies in the adrenal gland, it is wise to identify and divide the adrenal vein before actual manipulation and removal of the tumor is attempted. This may prevent the feeding of large amounts of vasopressor substances into the blood stream. The venous system of the paraganglioma is often atypical and such an approach in these instances may not be feasible. The tumor in this case was approached through a curving incision placed transversely across arose from an upper lumbar sympathetic ganglion. The tumor was intimately related with the renal vein and was separated from the vein with consider-

* Phentolamine Methanesulfonate U.S.P. (Ciba).

able difficulty, but was completely excised without the epigastrium. A spherical tumor measuring five centimeters in diameter was found lying in the pedicle of the left kidney. (See figure 2). It probably damaging the structures at the hilus of the kidney. Cardiac arrest occurred on three occasions during

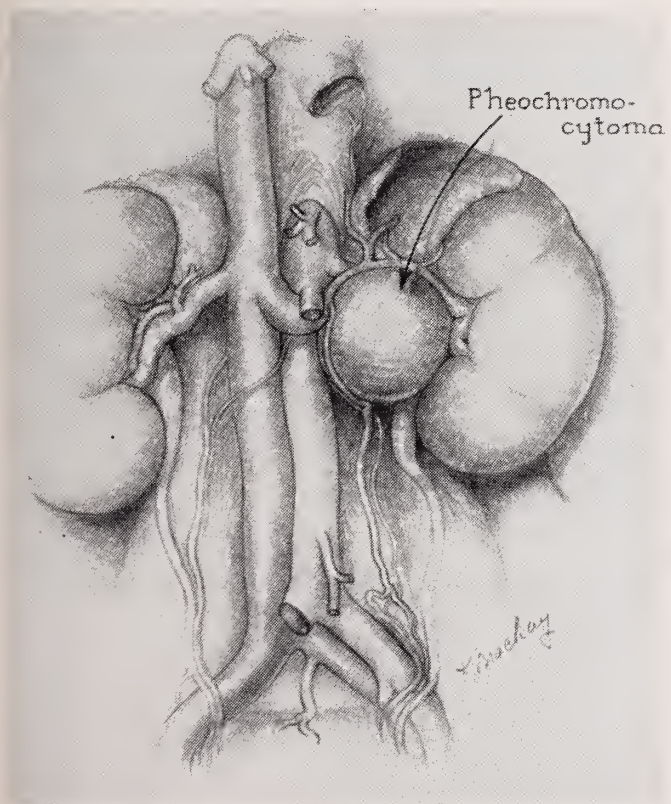


Figure 2

the excision of the tumor and was recognized promptly each time. Trans-diaphragmatic massage restored heart action almost immediately and following the third successful resuscitation no further cardiac difficulty was noted. Following removal of the tumor, and after a short rest period for the patient, both adrenal glands were deperitonealized and thoroughly explored. No abnormalities were noted, nor did further exploration of the paraganglionic areas demonstrate any abnormality.

Following removal of the tumor his pressure fell briefly to 90/80 and he left the operating room with a pressure 110/90. No Nor-epinephrine nor Neo-Synephrine were needed post-operatively to maintain his pressure. On the sixth post-operative day a histamine provocative test gave no evidence of persisting abnormal chromaffin tissue activity. A chest x-ray made on August 8, 1957 (figure 3) showed definite reduction of heart size and clear lung fields. He was discharged on August 9, 1957.

Five weeks later he was readmitted to Spalding Pavilion. Six days prior to this admission he developed facial edema, anorexia, nausea, vomiting, dyspnea, and upper abdominal pain. Blood pressure was 130/110. Pulse rate 160. Respirations were

30 per minute and temperature was 98.6. His neck veins were distended with the patient in a sitting position. A few basal pulmonary rales were audible. The liver was down three finger-breadths at the right costal margin. A harsh grade III systolic

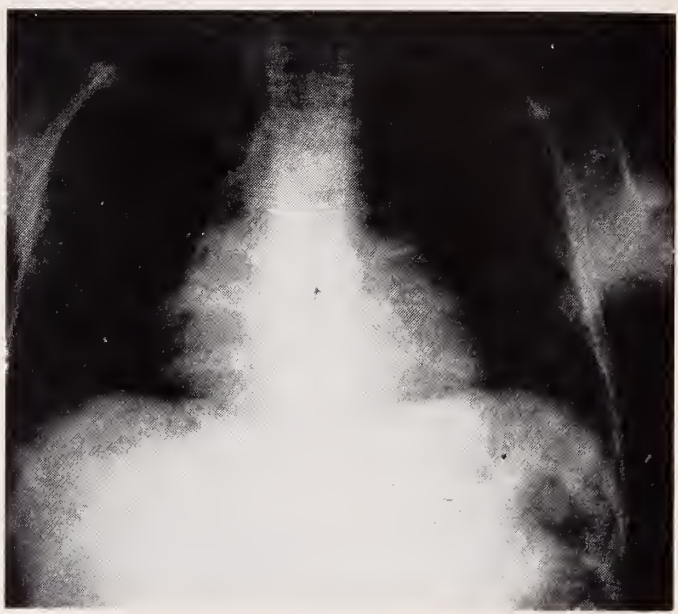


Figure 3

murmur was audible over the precordium, loudest at the apex, and an early grade I to II apical diastolic murmur was noted. BUN was 14 mgm. per cent. Hemoglobin and red count were normal. These symptoms promptly responded to re-digitalization, sodium restriction, and Mercurhydrin.* Protein-bound-iodine was 3.96 mcgm. per cent and I.V. pyelogram was again normal. Heart size was increased over post-operative findings, both to percussion and on chest x-ray. (See figure 4) Uri-

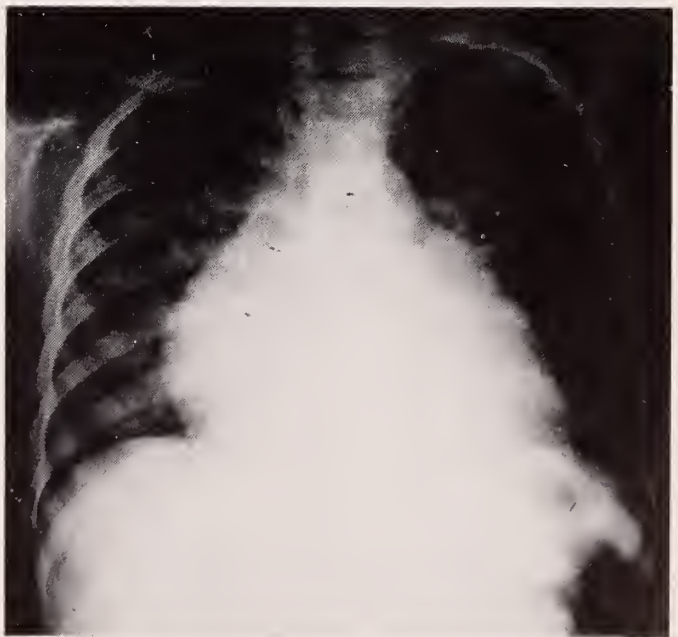


Figure 4

* Meralluride U.S.P. (Lakeside).

PHEOCHROMOCYTOMA / continued

nalysis on July 15, 1957: ph 5.5, specific gravity 1.012, 2 plus albumin, negative sugar and 10 to 12 wbc. Urinalysis reported on July 17, 1957 was identical. Urine culture again yielded no growth. Serum sodium was 137 meq./L, potassium 4.5, chloride 95.2 meq./L, and CO2 was not reported. After six days in the hospital he was discharged free of symptoms, to be maintained on low sodium diet, and digitalis.

He was observed at Aidmore Crippled Children's Hospital from September 19, 1957 through October 24, 1957. During this period his blood pressure reading varied from 130/90 to 160/112. A Regitine test was negative. Urinalyses showed specific gravities varying from 1.010 to 1.018, one to two plus albumin with only occasional rbc and wbc, and occasional hyalin cast. PSP test on October 21, 1957 showed 35 per cent excretion in 15 minutes, 23 per cent at 30 minutes, and a total of 71 per cent in one hour. Raudixin (Rauwolfia Serpentina Whole Root-Squibb) 50 mgm. tid failed to significantly alter the blood pressure course. Electrocardiograms were normal except for digitalis effect.

Blood pressure determinations on seven occasions in October and November of 1957 in Monroe County Health Department varied from 140/100 to 160/112.

On January 27, 1958 the patient was readmitted to Hughes Spalding Pavilion to consider the possibility of unilateral kidney disease, perhaps secondary to surgical injury to the blood supply of his left kidney. Prior to this admission a total of two histamine provocative and four Regitine tests had been performed since surgery. All failed to show evidence of persisting chromaffin tumor activity. Doctors William Bennett and William Morrison performed cystoscopy and retrograde pyelography, both were normal. Differential excretion performances of the two kidneys were compared:

	<i>Left Kidney</i>	<i>Right Kidney</i>
Volume	6.9 cc.	5.7 cc.
Total Protein	160 mgm. %	200 mgm. %
Urine Sodium	140.6	136.4
Urea	143.3	121.4

These findings seemed to exclude damage to the left kidney at time of surgery. Renal biopsy was considered but was not done.

Blood pressure readings at the Aidmore Crippled Children's Heart Clinic during 1958 were: April 120/74, May 150/84, August 110/85, and December 130/86. Reserpine was omitted in August 1958. Digitalis and sodium restriction were omitted in April of 1958. Urinalyses on three occasions since April of 1958 have indicated no albuminuria, and

microscopic examinations have been negative. Serial chest x-rays during 1958 showed gradual return of heart size toward normal. (figure 5) When seen on December 8, 1959 his blood pressure was 120/80 in both arms. A grade I to II apical systolic

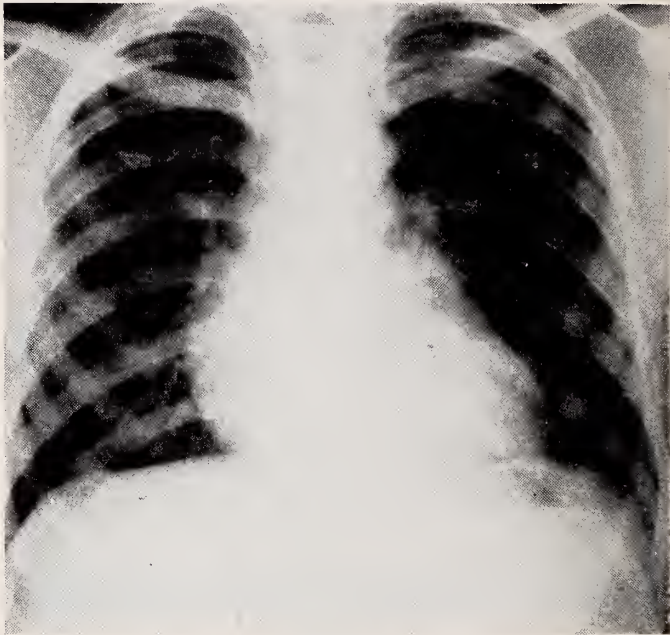


Figure 5

murmur was audible. Fatigue on unusual exertion was his only complaint. On January 10, 1961 his blood pressure was 110/70.

Discussion

The points of particular clinical interest in this case were: the patient's age, the characteristic signs and symptoms, his congestive heart failure, the severity of his hypertension, and its persistence for about five months after surgical removal of a chromaffin paraganglioma.

Of 207 cases of pheochromocytoma reported by Graham¹ about one per cent occurred in the first decade of life. In 47 cases in children under 16 years of age reported by Tevetoglu and Lee² seven were under seven years of age. In children, extra-adrenal tumors occur in about 25 per cent of cases. This is a much higher proportion than is found in adults. Males out-number female children with this disease by about two to one.

The four commonest complaints reported in Graham's series were headache, palpitation, vomiting and sweating. Of these our patient did not complain of the first two. He may have had headaches and palpitation but he was extremely shy and responded to questioning poorly. Vomiting and sweating were persistent and prominent, however. Sweating may be a means of heat loss to compensate for increased metabolic activity, or it may result from the direct action of epinephrine on sweat glands. His weight loss was probably due in part to vomiting.

However, weight loss is a very common manifestation of pheochromocytoma, even without vomiting. Non-pleuritic chest pain has been frequently reported in this disease. Chest pain in our patient was a dull boring anterior chest pain, largely retrosternal, which was unrelated to meals, respirations and exertion. It lasted an hour or so at a time and recurred several times daily.

Other symptoms sometimes seen in pheochromocytoma are increased thirst, anxiety, and irritability, abdominal pain, visual disturbances, polyuria, enuresis, convulsions, and symptoms of neurophysiological deficit, such as hemiplegia. This patient exhibited none of these findings.

The other symptoms noted in this patient were those attributable to cardiac decompensation. In Tevetoglu and Lee's² series of 47 children only one (case 8) developed congestive heart failure. In our patient cardiac decompensation was the cause of referral and the immediate threat to the patient's life. Although the patient now has a soft apical systolic murmur, there is no evidence that he had pre-existing heart disease. Myocardial failure seemed due to the severity and duration of his hypertension. The resulting damage was sufficient to permit recurrence of failure on discontinuing digitalis and sodium restriction. This occurred several weeks after surgery at a time when his blood pressure was only moderately elevated.

In adults, paroxysmal hypertension has been reported in 98 of 207 cases. In children it is very much less frequent. Paroxysmal hypertension occurred only once in the series of 24 children with pheochromocytoma. In the present case hypertension was sustained, though variable in severity.³

Although the hypertension noted in this patient prior to surgery was very severe (230/190 and 210/190) it was not uniquely so. 285/230 has been reported in a 12 year old and 260/210 in an 11

year old child with this disease.² However, we find no other instance of hypertension after surgery which was not due to a second chromaffin tumor. This possibility was excluded in the present case, both by repeated testing and by clearing of the hypertension with passage of time. In this instance the moderate hypertension (140/100 to 160/112) for several months was accompanied by albuminuria of mild to moderate degree. In view of the clinical course it seems reasonable to assume that the hypertension persisting after surgery was the result of renal damage which resulted from sustained severe hypertension. Pre-existing or co-existing bilateral renal disease of other cause has not been entirely excluded, however.

Summary

A case of pheochromocytoma (chromaffin paraganglioma) in a six-year old boy is presented. Important features of the surgical treatment of this condition are outlined.

Typical clinical findings are noted. Congestive heart failure is reported as an unusual complication in children with this disease.

Very severe sustained hypertension is noted as a prominent finding in this case. Hypertension persisting several months after surgery is discussed. Such persisting hypertension, not due to a second tumor, seems to be a unique feature of the present case among reported cases of chromaffin tumors of children.

21 Eighth St., N.E.

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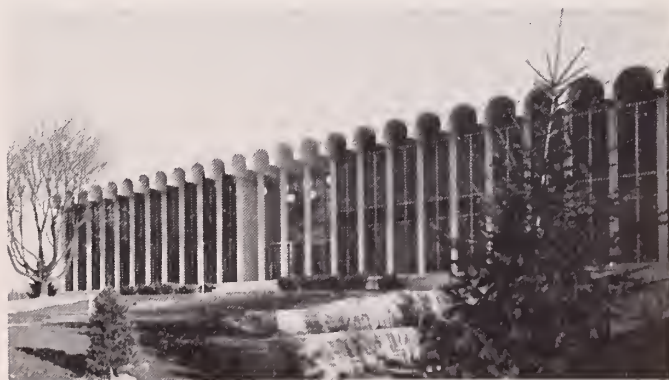
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NEW BUILDING IS DEDICATED FOR MICHIGAN STATE MEDICAL SOCIETY

Pictured to the right is the new building of the Michigan State Medical Society in Lansing, Michigan. The structure was designed by Minoru Yamasaki of Birmingham, Alabama. A distinguished feature is the white vaulted roof of pre-cast concrete. The semi-circular roof vaults are supported by tall columns of pre-cast quartz aggregate surface concrete. Much of the exterior wall is glass.

The two-story functional building contains approximately 20,000 square feet of floor space. In addition to offices and production rooms, the building has several conference rooms.

The new building was dedicated on June 4, 1961.



New Home of Michigan State Medical Society in Lansing

SURGICAL MANAGEMENT OF VARICOSE VEINS AND THE POST PHLEBITIC SYNDROME

P. C. Shea, Jr., M.D., *Atlanta*

Stripping alone will not cure these people.

CORRECTIVE SURGERY FOR PATIENTS with post-phlebitic syndrome presents certain problems. Elaboration of pitfalls in management and a description of methods relating to operative technic may produce an improvement in anticipated results. More particularly is this true when dealing with people who have previous surgical procedures for this syndrome. The patient frequently presents himself with two or more of the following changes: varicose veins, incompetent perforating veins, skin changes (discoloration and pigmentation), and edema. In addition, thickening may occur in subcutaneous tissue with or without a painful leg ulcer.

An adequate physical examination forms the basis for a successful result. Other causes of varicosities (e.g., arteriovenous fistula) and systemic causes for edema, etc. must be excluded. Concurrent adverse physical changes, such as obesity, chronic lung disease, et al, should be recognized for their influence upon the problem, or on operative morbidity. Specific attention is paid to the presence and location of perforating veins which have become incompetent. The latter are located by searching physical examination without the use of tourniquets or radiographic studies utilizing contrast media. Such perforators are best identified with finger tip palpation of a compressible lake, which redistends on removal of the finger. In areas where brawny induration and/or ulceration exists, malfunctioning veins are present and searched for through an incision at operation. Similarly, the details of contributing superficial collateral veins are noted, particularly those which link the internal and lesser saphenous system, because they, too, should be eradicated for an adequate result. Careful examination also elicits lesser saphenous insufficiency in many patients with postphlebitic changes.

A remarkable number of factors come into play in preoperative management, and a few of these are enumerated because of their importance. Bed rest

with elevation and chlorothiazide compounds are utilized for reduction of edema. A definite asset is elevation of the front feet of the bed on five-inch blocks. This has been shown to increase the rate of venous return three times normal and yet allows the patient to rest or sleep without discomfort. Such elevation, incidentally, has been used also is prevention of venous stasis after major surgical procedures. Antibiotics are employed as an adjunct to wound prophylaxis when necessary, or when an acute cellulitis is superimposed on chronic, brawny changes. PhisoHex,[®] so frequently utilized in preparation of patients for surgery, has been found to be allergenic in a moderate number of those with chronic stasis changes. When this reaction occurs, it is usually a vesicular or eczematoid type of response in the epidermis.

The surgical approach includes the conventional high and low saphenous ligations and stripping. Numerous warnings have been projected heretofore regarding individual ligation and division of each branch at the saphenofemoral junction; this must be re-emphasized because failure to do so allows for recurrence or persistence of difficulty. These patients have stripping procedures performed because it is remedial, but by no means an ultimate cure. However, careful attention to eradication of incompetent perforators is essential for a satisfactory result. With several perforating veins directly exposed, the stripper, threaded through the internal saphenous, can be removed, leaving most of the perforating veins intact. Little more proof than this is needed to demonstrate that stripping alone will not cure these people. This is further illustrated by attention to Fig. 1. The internal saphenous may connect to any of the branches labeled "C," the other "C" branches remaining intact to route blood to an ulcer or indurated area. Simultaneously, one can see why ligation of a perforator at "A" (just below deep fascia) is necessary, rather than at "B". Also, obliteration of

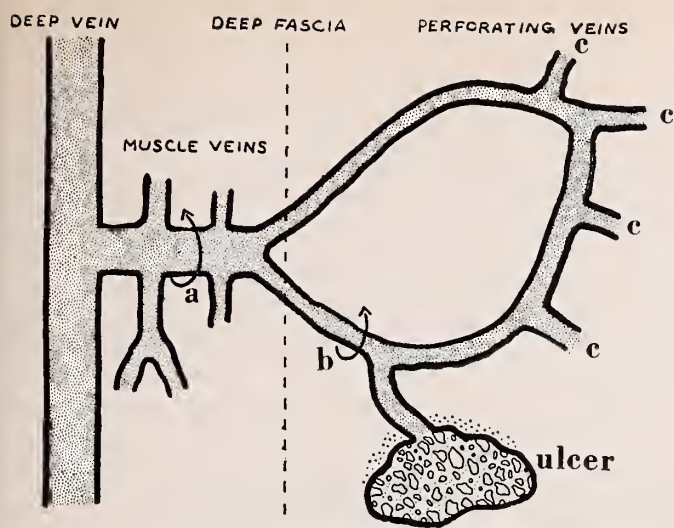


Figure 1. Venous circulation pertinent to surgical correction.

superficial collateral is important because it may enter this cyclic type of circulation at "C", influencing any distal disease. Many such functioning collaterals will be found to be linked directly with the lesser saphenous system, which is also frequently incompetent.

The incompetent perforating veins themselves are best attached through small incisions at previously identified problem areas. The incision extends down through the deep fascia for control of the vein as depicted (Fig. 1). In an indurated area where individual perforating veins are not identified, a long linear incision for direct exposure is utilized. When an ulcer is present, excision of the ulcer with the surrounding indurated area and underlying deep fascia readily exposes all the perforating veins which function in that particular area.

In all patients with persistent or recurrent difficulty after previous saphenous ligation, high saphenous wounds are re-explored. The percentage of existence of undivided, unligated branches at the bulb has approached 50 per cent of case incidence. Similarly, it has proven fruitful to pay close attention to the saphenous area just below the knee, for here bifur-

cations and trifurcations have been functioning to increase insufficiency in the face of ligation (or stripping) of one branch.

Excision and grafting of ulcerated areas can be carried out in one or two stages. Two-stage procedures are used when infection is apt to interfere with graft healing. Here, granulations are allowed to develop before a skin graft is performed. As previously mentioned, excision includes the ulcer and all the surrounding indurated area, as well as the underlying deep fascia. Simultaneously, all perforators in the area are ligated. Whether grafted primarily or secondarily, the rate of healing has been uniformly good provided adequate venous surgery has been done. Nothing is strikingly new about this phase of surgery in chronic venous insufficiency for Homans performed such grafts as early as 1917.

Post-operative care is important—sometimes tedious—but important. Elevation of the foot of the bed with five-inch blocks is necessary. Early active exercise is recommended, even while recumbent. In less radical procedures, ambulation is started 48 hours after surgery. Where skin grafts have been done, bed rest is instituted for 14 days to allow for complete healing of the skin graft. Elastic wrappings are used post-operatively, and elastic stockings are fitted and worn when the patient is again in the upright position. For patients who have any edema, either intermittent or persistent, post-operatively 500 mgm of chlorothiazide are ordered, twice weekly, orally. All patients are cautioned that this is a chronic disease, and certain reasonable hygienic measures and routine care on their part is necessary for a satisfactory future.

One additional aid is the use of 50 per cent dextrose solution, or 10 or 20 per cent sodium chloride for a sclerosing agent in those cases which require injection after discharge from the hospital. It avoids the possibility of adverse reactions, such as urticaria, angioneurotic edema or shock, which occasionally accompany more commonly used agents.

384 Peachtree Street

The author is indebted to Edith Collins for production of Figure 1.

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HYPOFIBRINOGENEMIA IN PREGNANCY

T. E. Rogers, M.D., *Macon*

A review of cases at the Macon Hospital over the past three years is presented.

FROM 1915 TO 1953 there was a reduction in the maternal mortality of the white population in the United States from 60 per 10,000 live births to slightly more than four. In this 38-year period the non-white mortality rate decreased from slightly over 100 per 10,000 live births to approximately 17.¹ The maternal mortality in Georgia for 1959, as found by our maternal mortality committee, was 89, representing 99,458 live births, or 8.9 per 10,000. There were 24 white and 65 non-white deaths.²

The three most common causes of maternal death are hemorrhage, infection, and toxemia, and these three account for about 90 per cent of all maternal deaths.¹ Of these three, hemorrhage is the most important today, because the deaths from infection and toxemia have been so remarkably reduced. For example, in 1935, 13.6 per cent of deaths in the United States were due to hemorrhage, whereas in 1952 that figure had increased relatively to 46.2 per cent.¹ This does not imply that more women are dying from hemorrhage, but that fewer women are dying from other causes. Of Georgia's 89 maternal deaths in 1959, 13, or 14.6 per cent were due to hemorrhage, a relatively lower figure due to our higher incidence of toxemia.²

In general there are five causes of post-partem hemorrhage: uterine atony, which accounts for 80 per cent; bleeding from the placental site, 10 per cent; lacerations of the genital tract, seven per cent; retained secundines, two per cent; and defects in clotting mechanism, one per cent. It is the last of these five causes, this one per cent of the causes of

post-partem hemorrhage, to which I invite your attention. Defects of the clotting mechanism may occur as the result of 1) hypofibrinogenemia, 2) thrombocytopenic purpura, 3) aplastic anemia, 4) anticoagulant therapy, and 5) severe vitamin deficiency.³

To narrow the field, consider only number one of the five, hypofibrinogenemia. The preceding facts have been reviewed merely to show the relative statistical position of our subject. Recall one other condition related to this subject. In 1926, in Brazil, J. R. Meyer described a phenomenon identified as amniotic fluid embolism.⁴ In 1941 Steiner and Luschbaugh established it as a clinical entity.⁵ Statistically it is a rare complication. In a Minnesota survey there were 15 deaths from amniotic fluid embolism in over 500,000 births, an incidence of one case for every 37,000 births. Even so, it was listed as number five among obstetrical causes of death in this Minnesota maternal mortality study, and accounted for 6.4 per cent of obstetrical deaths.⁶

Amniotic fluid embolism, or as it has more recently been termed amniotic fluid infusion, involves the infusion of amniotic fluid, possibly containing lanugo, meconium, vernix, and decidua into the maternal circulation.¹ When the membranes have been ruptured the amniotic fluid may find its way between the membranes and the uterine wall, by some mechanism not fully understood, most likely at the site of placental implantation, and thus into the venous sinuses of the uterus. This amniotic material then accompanies the maternal venous circulation, where it

acts chemically as a thromboplastic agent, the end result of which changes thromboplastin into thrombin, then fibrinogen into fibrin. Consequently clotting occurs in the maternal venous circulation. The clinical picture which follows in the reported cases is remarkably consistent: chills or complaints of feeling cold; restlessness and apprehension; dyspnea and cyanosis; finally profound shock, due to intravascular clotting and defibrination of blood. There may be pulmonary edema, and if the embolus is large enough there may be blockage of the vessels in the lungs and acute dilatation of the right side of the heart. There is thought to occur, also, anaphylactoid shock. Nervous reflexes initiated in the lungs produce bronchospasm. In the 15 cases reported in the Minnesota study, all 15 women died, five of them in less than 30 minutes after the onset of symptoms, and the last one in nine hours.⁶ There may have been non-fatal cases but such do not seem reportable, since the diagnosis is made at autopsy with the finding of amniotic material in the pulmonary vessels.

Amniotic fluid infusion is so rare that only by keeping it in mind will it be entertained as a possible etiological factor in cases of non-hemorrhagic obstetric shock. It is most frequently associated with increased uterine tension such as in terrific, tetanic type labor, whether spontaneous or associated with oxytocic drugs, or with a large baby, or with abruptio.

Rapid and vigorous treatment is necessary; oxygen; morphine for restlessness and apprehension even in the presence of cyanosis and shock; intravenous injections of papaverine and atropine to block vagal effects and relieve spasm of the vessels and bronchial walls; aminophyllin and tourniquets applied to the limbs, or phlebotomy, might be helpful. Intravenous heparin, given early, has been suggested, since small amounts of heparin inactivate large amounts of thromboplastin; and intravenous fibrinogen should be given.^{1,6} Hemorrhage is not necessarily a part of this picture, but may occur because of uterine atony following vascular collapse, as well as from the clotting defect associated with defibrination.¹

Amniotic fluid infusion has been mentioned because of its relation to hypofibrinogenemia. As we have seen, the fluid infusion syndrome is very rare. Hypofibrinogenemia is not so rare. Although the amniotic fluid shock picture seldom precedes the more common hypofibrinogenemia, the patient who does not die from the mechanical blockage of the pulmonary vascular system, the anaphylactoid reaction, or the atonic uterine hemorrhage may find herself in defibrination hemorrhage.

In 1901 De Lee noted that women with placental abruptio in the severe forms frequently demonstrated a blood coagulation defect.⁷ Now we realize

that women with placental abruptio, women with intra-uterine death of a macerated fetus usually of over four months gestation and most often when the fetus has been dead for five weeks or longer⁸, women with amniotic fluid infusion, with severe toxemia, abortion, traumatic surgery with cesarean section or ectopic pregnancy, ruptured uterus, acute bacteremia under certain circumstances, and transfusion of mismatched blood, all may develop the hypofibrinogenemic coagulation defect. The latter two, bacteremia and mismatched transfusions, are thought to be associated with the Schwartzman-like reaction resulting in intravascular fibrin formation in the presence of a fibrinolytic or fibrinogenolytic agent.⁹

The principal characteristic of hypofibrinogenemia is, of course, uterine hemorrhage without sufficient clotting, often massive in nature, and quickly resulting in profound vascular collapse. It probably results from several mechanisms. As in amniotic fluid infusion the thromboplastin from amniotic fluid, placental juices, decidua, etc., form thrombin which changes fibrinogen into fibrin, resulting in clotting in the maternal veins. This decreases the circulating fibrinogen, normally about 10 to 12 grams, sometimes to a point at which the mother's blood loses the ability to clot as it escapes from the uterine wall and at other available portals of exit. Also it has been shown that, in cases of abruptio, the continued bleeding and clotting within the uterine cavity at the site of placental separation may use up a large quantity of fibrinogen. In seven cases of abruptio with hypofibrinogenemia it was shown that two-thirds of the fibrinogen calculated as lost from the circulation was recovered as fibrin from clots taken from the uterus. So we see that fibrinogen may be depleted in an extravascular as well as intravascular location.¹⁰

Phillips, Montgomery, and Taylor presented cases of decreased fibrinogen in which proteolytic enzymes were demonstrated, which manifested fibrinolytic and fibrinogenolytic activity. It was their belief that such enzymes could have been at least partly responsible for the low fibrinogen levels. They also showed that the quantity of these enzymes decreased as the fibrinogen levels increased, following administration of fibrinogen.¹¹ It is not unreasonable to imagine an extension of this proteolytic activity resulting in the depletion of circulating fibrinogen in the general circulation, thereby further complicating the situation.

Another possible contributory factor is the exhaustion of the hepatic production of fibrinogen, the depletion being so rapid that the liver, partly from ischemia and shock, loses its capacity to replenish the supply.

Longo, Caillouette, and Russell have reviewed this subject and remind us that clotting deficiency may be

due also to the presence of a heparin-like factor. They described the laboratory tests indicated to show the presence of fibrinolysins as well as the heparin-like factor. Because of the time required for these procedures, bedside clotting tests were explained which are time-saving and reliable.¹² Since there is evidence to support these various theories, and since no one knows exactly what happens to the fibrinogen, we must, for the present, admit that there are several possible mechanisms involved.

For the patient known to have a dead fetus in utero, fibrinogen determinations should be made by the laboratory at weekly intervals, beginning not later than three weeks after the diagnosis of fetal death is made.¹³ The fibrinogen level in the pregnant woman at term normally ranges from 200 or 300 to 700 mgm. per cent. A level below 150 mgm. per cent is considered potentially dangerous, and Eastman says that a level below 100 deprives the blood of its clotting ability.¹ If a patient with a dead fetus has less than 150 mgm. per cent, action toward delivery with adequate blood and fibrinogen available should be considered, even abdominally if vaginal delivery cannot be accomplished. Any patient who develops toxemia must be considered a potential candidate for this condition, since it is known that many toxic patients show a relatively, though not dangerous, low fibrinogen level. Any patient who is admitted with bleeding, and any patient who is admitted with, or develops, abruptio, mild or severe, must be watched closely, and the fibrinogen status determined at intervals.

There are four tests for hypofibrinogenemia. The first, most rapid, and simplest is the clot observation test, in which five cc. of the patient's blood is drawn, placed in a test tube, and observed. Normally a clot should form in five to ten minutes and remain stable. If the fibrinogen level is low the clot will fail to form, or not remain stable. If fibrinogen has been given, this test can be repeated at intervals of 15 to 30 minutes to determine the point at which a safe level has been reached. By this time, of course, clots will be seen in the vagina, on the drapes, and possibly, on the floor.

Second is the fibrindex test, a laboratory qualitative test, reported as normal or subnormal, indicating a blood level above or below 100 mgm. per cent.

The third is simple observation for hemorrhagic diathesis, noting non-clotting blood on the bed and drapes, bleeding and ecchymosis at venapuncture sites, episiotomy repair, gums, etc.

The fourth is the quantitative laboratory test which reports the actual mgm. per cent of fibrinogen in the blood plasma. It is time consuming and the report

may not arrive until the crisis has passed. Even so, it should be done.

Two other rapid bed-side tests, which Longo and his Los Angeles co-workers discussed, are one for heparin-like factor and one for fibrinolysins. The heparin-like factor test is performed by mixing equal parts of maternal and control blood in a test tube. If the combined blood fails to clot, heparin-like factor is present. The test for fibrinolysins is performed by mixing equal parts of maternal blood with clotted normal control blood. Lysis of the clot in the normal blood indicates the presence of fibrinolysins.¹²

As for management of hypofibrinogenemia, since the placenta is the usual source of thromboplastin, the sooner the patient is delivered of fetus and placenta the sooner her source of thromboplastin will be removed. On the other hand, operative interference such as cesarean section prior to the restoration of the fibrinogen level might prove disastrous. If this is attempted there will be bleeding from the uterine incision, or from the stump or vault if the uterus is removed, from all cut and sutured layers of the abdominal wall and skin. Bleeding from these areas may not be as profuse as from the placental site in the uterus, but, if combined with the trauma of surgery in a patient in, or bordering on, shock and with inadequate circulating fibrinogen, it may be too great a load to bear.

Artificial rupture of the membranes will relieve the increased intra-uterine pressure and reduce the amount of thromboplastin infused into the mother's circulation.

Treatment of hypofibrinogenemia, or fibrinogenopenia, when it is diagnosed, must be immediate and aggressive. Oxygen is given at once; eighteen gauge needles, or larger, are placed in two veins, if accessible. If the veins are collapsed, dissection for veins should be done and polyethylene tubing inserted. On rare occasions an intra-arterial route may be necessary, even through the iliacs if the abdominal approach for delivery has already been undertaken. Fluids should be given until blood and fibrinogen are at hand. From two to ten grams of fibrinogen, and sometimes more, is required to restore the level to normal. Each unit contains approximately two grams of fibrinogen. Blood must be given rapidly and in quantity sufficient to treat shock and replace blood loss, which is usually underestimated. Calcium should be given after several units of blood. Blood alone will not restore the fibrinogen level. Vasoconstrictor drugs as a temporary measure, and adrenal corticosteroids, intravenously, are used for support. Plasma expanders tend to prevent the conversion of fibrinogen into fibrin and should not be used.¹² For anesthesia, if delivery has not been accomplished, pudendal block or general anesthesia are preferred

to spinal. Delivery must be carried out as soon as the fibrinogen has been returned to a safe level. Adequate and able help is essential. This is a time when the first team is needed. Any physician who has experienced this type of hemorrhage will never forget it.

Depending on the severity of the condition, strong uterine muscular contractions, especially around the placental site, following delivery, may sufficiently decrease the blood and fibrinogen loss so that the level may spontaneously rise again before exsanguination can take place, even without the administration of fibrinogen.

If the coagulation defect has been found to involve the heparin-like factor, protamine sulfate is indicated, 20 to 50 mgm. slowly, intravenously, and is not to be repeated unless further tests show that heparin-like factor is still present. On the other hand, if fibrinolysin is found to be present, intravenous hydrocortisone in 200 mgm. doses should be given.

There are long range results of shock in pregnancy, particularly concerning the anterior pituitary and the kidney. Sheehan's syndrome is one in which the anterior pituitary has undergone some degree of necrosis following pregnancy shock. As for the kidney, acute tubular necrosis may occur with lower nephron nephrosis with its fluid and electrolyte complexities, if not irreparable renal damage. Hemolysis due to administration of incompatible blood may occur and cause acute renal failure. In such an emergency as hypofibrinogenemia, with confusion in the blood bank and delivery suite, the wrong blood might be given by mistake.

As with every drug, apparatus, or procedure which becomes available, fibrinogen has been abused. It has been used in cases of hemorrhage not associated with hypofibrinogenemia. Before fibrinogen is used, it must be determined that this condition is present, and that the hemorrhage is not due to some other more common cause. Homologous serum jaundice occurs in approximately one out of 20 patients receiving fibrinogen.

At the Macon Hospital from January 1, 1958 through December 31, 1960, 12,004 babies were delivered. During this three year period 19 cases were diagnosed as hypofibrinogenemia. Thirteen were private patients, six service. Twelve were white, seven colored. Of the 19, there were 11 stillbirths, and there were 11 cases of abruptio, which accounted for ten of the stillbirths. One was delivered by cesarean section and one by cesarean hysterectomy. Two had experienced third trimester bleeding and five had had toxemia prior to admission. Thirteen of the 19 were in shock for some period of time, and six were not. Two were admitted in shock, and one patient recovered from shock during labor, to go

into shock again following delivery. Fibrinogen administration varied from 0 units to six, and blood from one to ten units.

Post-partum complications were as follows: two patients had pulmonary embolus; three had oliguria for several days during which time lower nephron nephrosis was feared but never proven; four patients had jaundice in from two to four months after delivery; one patient had pulmonary embolus and, later, jaundice; another had EKG diagnosis of "sub-endocardial ischemia" and was digitalized; this patient also had pyelonephritis and, later, jaundice. One unusual case occurred after premature delivery associated with placental separation. She was readmitted 18 days later, and a D and C was done for continued bleeding. Hypofibrinogenemia developed following the D and C.

Either the fibrinogen level was below 150 mgm. per cent, or the blood was recorded as not clotting or clotting very poorly, in all 19 cases. Thus it appears that fibrinogen administration was indicated in every case.

There was no maternal mortality.

Summary

A brief review has been given on the subject of hypofibrinogenemia in pregnancy, and the theories as to its causes and contributing factors. Laboratory help which is available, both bedside and quantitative tests, have been recalled. Amniotic fluid infusion has been mentioned because of its relation to hypofibrinogenemia. The management of these conditions has been suggested and, finally, a review of cases at Macon Hospital over the past three years has been presented.

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Guide for Completing Medicare Claim Forms

MEDICARE DEPARTMENT, Medical Association of Georgia, calls the attention of all physicians to the important data listed below:

The following information is necessary to process a Medicare claim on Form 1863 and when not completed often delays payment for services rendered.

1. (a) Spouses and children *residing apart from sponsor* will be allowed selection of either uniformed services medical facilities or civilian sources for care authorized under the Program.
(b) Spouses and children *residing with sponsor* and desiring care at government expense will be required to utilize a uniformed service medical facility in the area in which residing if medical facilities are available as determined by the Commander of the medical facility. When uniformed services facilities are not available a Medicare Permit or a NON-AVAILABILITY STATEMENT (Form DD 1251) will be furnished such dependents by the appropriate Commander authorizing them to seek medical care from civilian sources. This statement must be attached to the claim form. (Item 4).
2. (a) Medical Authorization Card Number (Form DD 1173)—(Item 6).
(b) Expiration Date (Item 7). The card is valid only from the date of issue and through the expiration date shown thereon.
3. Two signatures of either spouse or sponsor (Section III, Item 14) are needed in cases involving obstetrical and maternity care.
4. (a) Each period during which service was rendered (Item 18).
(b) In maternity cases, give date of first antepartum visit.
5. Complete diagnosis according to the standard nomenclature (Item 20).
6. (a) List services rendered and type of procedure (Item 22).
(b) In maternity cases, give date of delivery and in anesthesia cases, the name of surgeon or obstetrician.
7. State if any fee has been paid by or is due from patient (Item 26).
8. Either block A or block B (Item 29, paragraph one), to identify the status of the billing physician must be checked. *In addition*, either block A or block B (Item 29, paragraph two) indicating the amount acceptable as full payment must likewise be checked. If block B in the second paragraph is checked, the physician must include a Special Report. The report must support the amount charged as justification for services of unusual degree or for authorized services not covered in the schedule of allowances.
9. The physician whose name and address appears in Item 16 must sign the claim form. A rubber stamp is not acceptable (Item 29).
10. Present schedule of allowances is listed in Medicare Manual (1961 Edition) and is available upon request by physicians. Write Medicare, Medical Association of Georgia, 938 Peachtree Street, N.E., Atlanta 9, Georgia. Telephone TRinity -6303.

FILM ON VIRAL MENINGITIS

THE NATIONAL FOUNDATION is pleased to announce the availability (August 1, 1961) of a new teaching film, THE DIAGNOSIS OF VIRAL MENINGITIS.

The film was prepared by members of the staff of the University of Kansas Medical Center and of the Kansas City Field Station Unit of the U. S. Public Health Service. It covers clinical diagnosis and epidemiological considerations; the collecting and

handling of specimens for the laboratory; definitive laboratory procedures for isolation and identification of etiologic agents; new and faster methods of laboratory diagnosis.

The film is 16mm, color, sound, and runs approximately 35 minutes. It may be borrowed free of charge, except for return postage and insurance, by writing the Department of Professional Education. At least three weeks' advance booking is requested.

VESICoureTERAL REFLUX IN CHILDREN

J. Gary Palmer, Jr., M.D.; Donald R. Rooney, M.D., *Marietta*

This condition if allowed to continue untreated will result in irreversible renal damage.

IN THE PAST FEW YEARS, the problem of vesicoureteral reflux in children has drawn much attention. It is our purpose in presenting this paper to discuss the outstanding problems encountered in the diagnosis and treatment of this condition. Vesicoureteral reflux may be defined as the regurgitation of urine from the bladder into the upper urinary tract.

Earlier reports in the literature would lead one to believe that vesicoureteral reflux is not an abnormal finding.^{1,2} Most authorities now agree that vesicoureteral reflux is never normal. However, there is some difference of opinion as to the cause of reflux and as to the best method of treatment.

In a recent panel discussion on reflux presented before the American Urological Association in Chicago, Dr. Victor Marshall³ outlined the following mechanisms of the normal vesicoureteral junction in preventing reflux. (1) The length of the intramural ureter. (2) The caliber of the intramural ureter. The normal ratio between the length and the caliber of the intramural ureter is about eight to one. (3) The degree of collapsibility of the intramural ureter. (4) The ureter must be anchored at its lower end. (5) There must be a firm muscular backing behind the intramural ureter. (6) There must be intravesical pressure present to create reflux. However, reflux is not dependent upon high intravesical pressures.

Vesicoureteral reflux is due to some type of obstruction at or below the bladder neck in well over 90 percent of the cases. There are other causes, most of them being related to anomalies or to some defect in the neuromuscular system. In our 32 cases

of reflux, one was on the basis of a neurologic disorder, two had reduplication of the upper tract with one of the ureters draining into an ectopic ureteral orifice, the remaining 29 children had an obstruction at or below the bladder neck.

The symptoms these children present may be varied. Most of these children are seen after repeated episodes of unexplained fever and pyuria. A few have only enuresis and incontinence during the day. This may be seen in a previously trained child. Abdominal pain is not a frequent symptom. Straining to void is occasionally noticed by the parents. Failure to grow or to keep up in school work also may have been noticed by parents.

There are no significant physical findings unless an episode of acute pyelonephritis is present.

The excretory urogram, in other conditions, is the "may stay" of urologic diagnosis; but here it often fails us. Three-fourths of children with reflux have normal excretory urograms.⁴ This does not mean that we do not utilize the intravenous pyelogram. It is a valuable test in evaluating the upper tracts. It does mean that we must resort to a somewhat different technique for our diagnosis.

A carefully performed cystogram or voiding cystourethrogram, done without anesthesia, usually makes the diagnosis of reflux. (Figure 1.) This procedure is simple, involves no special equipment, and requires only a few minutes of the physician's time. First a preliminary scout film of the abdomen is taken being certain to include the kidneys, ureters and bladder on the film. Position and radiographic

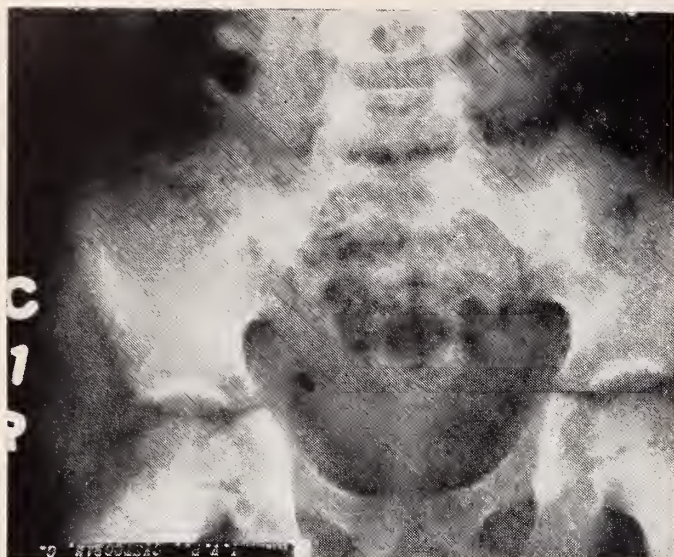


Figure 1-A. Routine Cystogram Series on an eight year old white male. No reflux, posterior ureteral valves or residual urine demonstrated. Preliminary scout film includes entire bladder, ureter, kidney areas, and labeled "C" to avoid confusion with I.V.P. films. Position and technique may be checked before opaque medium injected.

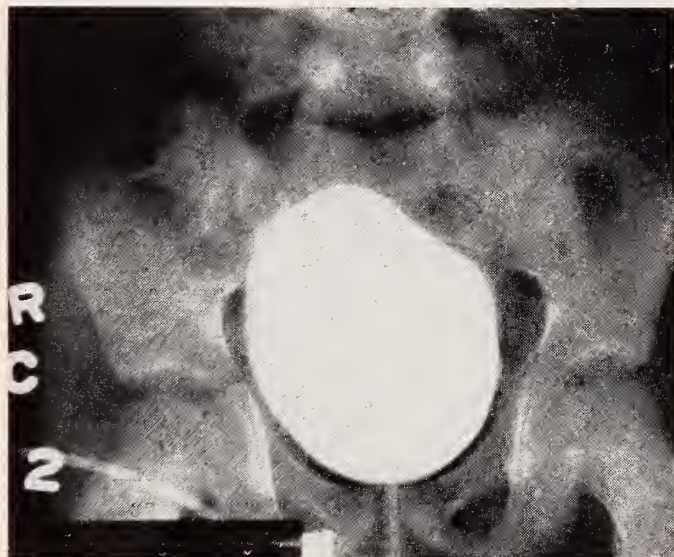


Figure 1-B. Film taken immediately after instilling 150cc of 10 per cent Hypaque: Note lead shield over gonads.

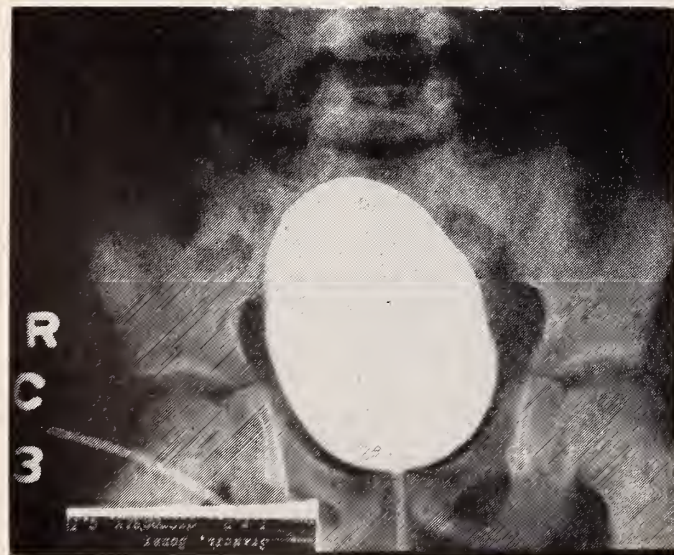


Figure 1-C. Delayed film taken 20 minutes after opaque medium instilled.

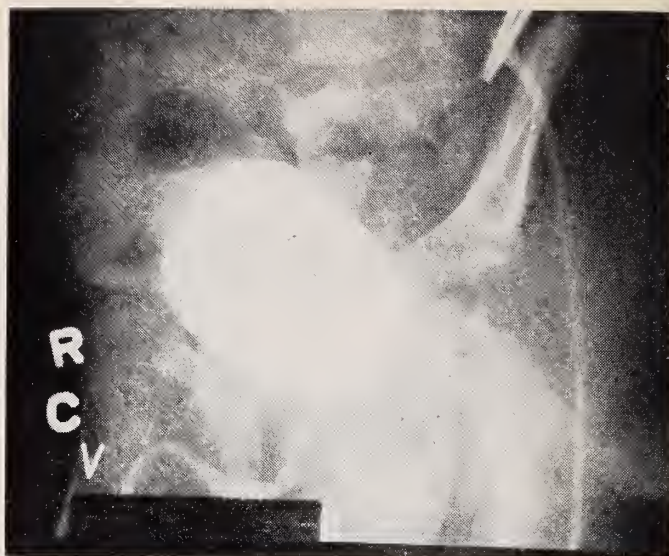


Figure 1-D. Erect voiding cystourethrogram taken in right posterior-oblique position. This film is omitted in females.



Figure 1-E. Post-voiding film. Unless this film is made immediately after voiding, refluxed urine may drain into the bladder and be misinterpreted as residua.

technique are checked on the initial film and corrections made if necessary. Next, a small soft rubber catheter is passed into the bladder using strict aseptic technique. We do not use a Foley catheter. The bladder is emptied, and the urine can be saved for culture or urinalysis if desired. The bladder is then slowly filled by gravity pressure using an asepto syringe without the bulb. A second film is made after 150cc of 10 per cent Hypaque have been instilled. The catheter is clamped while the film is being developed. If no reflux is seen on this second film, the technician is instructed to wait 20 minutes before making the third film. Following this, the child is allowed to void. Withdrawal of the catheter usually initiates voiding. If the patient is a cooperative male an oblique film is made while he is voiding in the erect position. If the patient is a female or

an uncooperative young male an immediate post-voiding film is obtained. Reflux is frequently observed only on the voiding or the immediate post-voiding film. If there is any delay in obtaining the post-voiding film the contrast media will again pass from the ureters into the bladder and be misinterpreted as residual urine.

Cystoscopy and cystourethroscopy are routinely carried out. Enlarged, patulous, widely separated ureteral orifices are frequently seen in children with reflux. These may also be seen in children in whom reflux is suspected but not demonstrated by cystography. Refluxing ureters may also have a normal cystoscopic appearance. The bladder neck does not often show any marked change. However, some subtle changes may occasionally be noted. Quite frequently the bladder neck remains only partially open while the irrigating fluid is running into the bladder. The bladder neck may not completely close when the flow of fluid is stopped. A smooth high posterior lip at the bladder neck is often seen. It is important to fill the bladder to capacity. In some children this is the only way a bladder neck contracture can be demonstrated. The bladder wall may be heavily trabeculated or very smooth. Deep cellulite formation is frequently seen. It should be reemphasized, however, that these children may have normal excretory urograms and normal cystoscopic findings even when there is marked reflux.

The greatest difficulty is to decide how these children with reflux should be treated. In a complex problem such as this, no single method of treatment will cover all cases. Certainly there is room for conservatism. Periodic urethral dilations and close supervision may be sufficient to control the child with minimal reflux. Many of these children will require antibiotics. These children must be watched carefully for signs of progression. If repeated studies show continued reflux with persistent or recurrent infection, or if a gradual deterioration of the upper tract takes place on conservative treatment, then certainly, some type of surgical intervention is necessary. Most investigators do not feel that this is a rapidly advancing disease. However, there is a sense of urgency in those cases where marked hydronephrosis and hydroureters are present on the initial studies.

There are no clear cut indications as to the surgical methods to use. Some feel that revision of the bladder neck alone is sufficient, and that additional procedures may be carried out later if improvement is not achieved. Others hold that the important thing is to stop the reflux and thereby stop further upper tract damage. Most who would revise the ureterovesical junction would also revise the bladder neck at the same time. The most widely used procedure

on the bladder neck is a Y-V plasty on the anterior bladder neck and the wedge removal from the posterior bladder neck.

Two general types of revision on the ureters are used. One is the method described by Hutch.⁵ The other is the re-implantation technique described by Politano and Leadbetter.⁶ Both of these methods are successful in correcting reflux in most cases.

In a few of the most severe cases where extreme upper tract damage has taken place, some type of urinary diversion may be indicated. At the present time, creation of an ileac bladder is the most popular procedure. This provides good upper tract drainage without internal tubes. Long term follow up is mandatory in all these children. Antibiotics should be continued as long as there is pyuria. Post-operative radiographic studies are usually not necessary until approximately six months have passed. After this, both excretory urograms and cystograms are obtained. Thereafter, cystograms should be repeated at six-month intervals. Excretory urograms can be done less frequently, as indicated.

In the past two years at Kennestone Hospital, cystograms have been obtained on 102 children between the ages of seven months and 16 years with various urinary tract signs and symptoms. The two most common findings were unexplained recurring episodes of pyuria and fever. Reflux has been demonstrated in 32 of these children. Of these children showing reflux 24 (75 per cent) were female. Fourteen children had bilateral reflux and 18 had unilateral reflux, representing a total of 46 refluxing ureters. Revisions have been performed on 26 ureters. None of these ureters has shown post-operative reflux although three have shown very mild obstruction. All of these children have shown marked clinical improvement. Three children have continued to have pyuria when not on antibiotics. Two of these have subsequently shown reflux in the contralateral, unoperated ureter; in which reflux was not demonstrated before the time of surgery. The other child has a partial post-operative ureteral obstruction. Representative cases are illustrated in figures two, three, and four.

Summary and Conclusions

Vesicoureteral reflux does not occur in the normal child. Reflux is a reliable sign that there is some underlying causative urinary tract disorder. Reflux may be due to a variety of causes, the most prominent being obstruction at or below the vesical outlet. Untreated, continued ureteral reflux will result in progressive irreversible renal damage. Reflux should be suspected in any child presenting recurring episodes of fever and pyuria. Abnormal physical findings may be entirely lacking. Excretory urograms

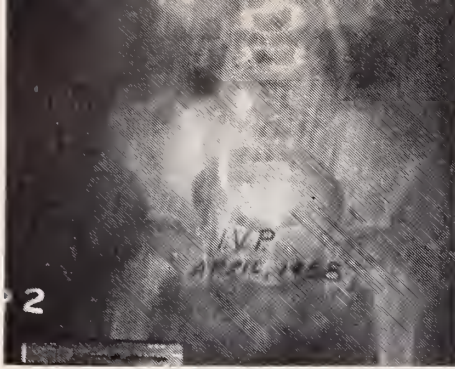


Figure 2-A



Figure 2-B

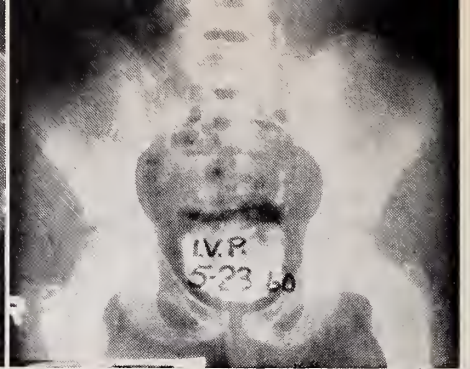


Figure 2-C

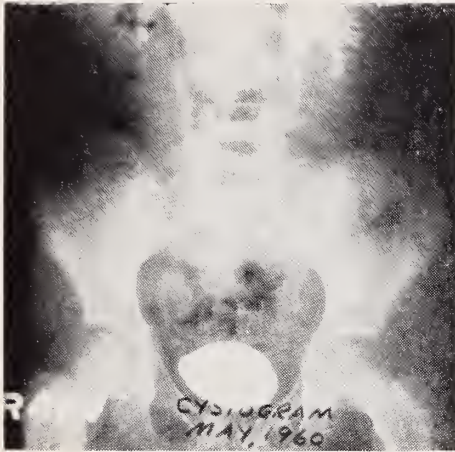


Figure 2-D

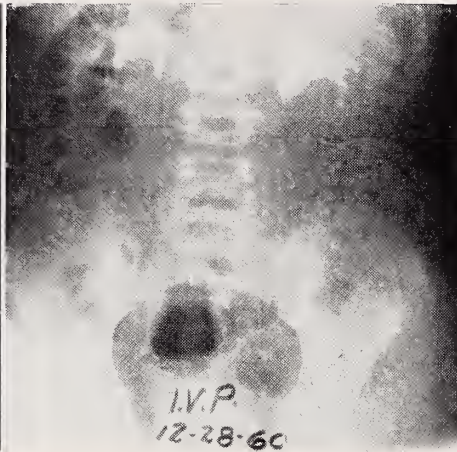


Figure 2-E

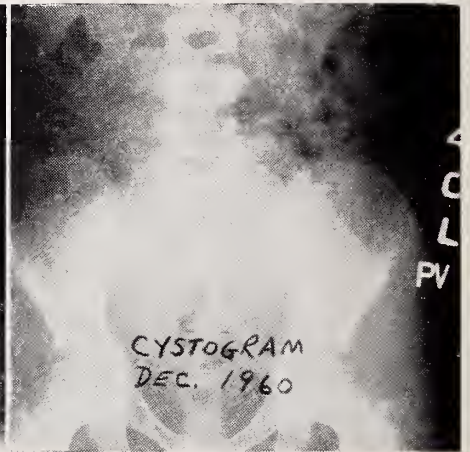


Figure 2-F

Figure 2. Two and one-half year old white female with almost continuous fever and pyuria since birth with *Klebsiella pneumoniae* organisms cultured on three occasions; slowly responded to chloromycetin. (a) Excretory urogram showing no marked abnormality. (b) Cystogram showing prompt bilateral reflux using only 50cc contrast medium. (c) Excretory urogram showing no significant change after two years conservative therapy with antibiotics and

urethral dilations. (d) Post-voiding cystogram made on the same date as "c." Bilateral reflux and residual urine again noted. (e) Excretory urogram made six months after vesical neck revision and bilateral vesicourethroplasties. Ureteral dilation no longer present. (f) Post-voiding cystogram, same date as "e." Complete absence of reflux and residual urine.

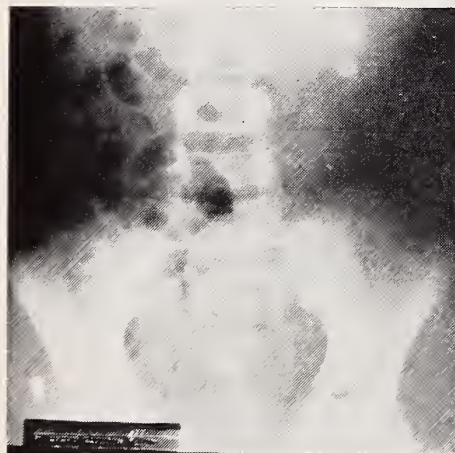


Figure 3-A

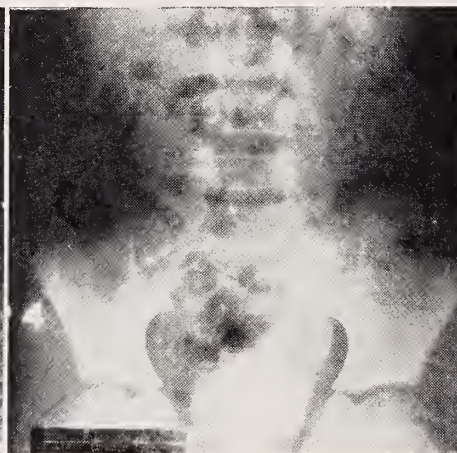


Figure 3-B



Figure 3-C

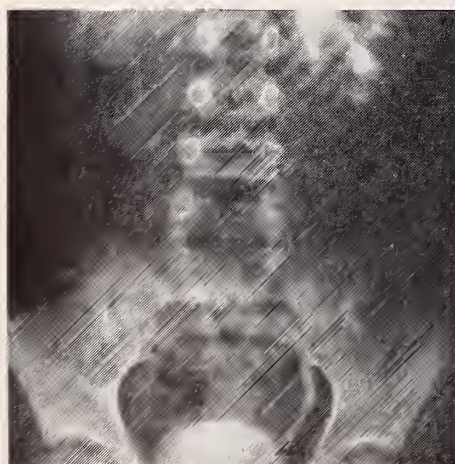


Figure 3-D

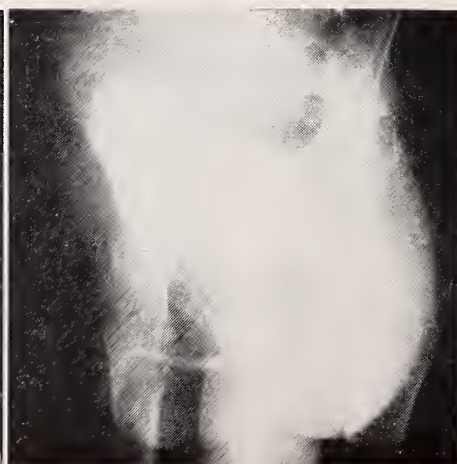


Figure 3-E

Figure 3. Eight year old white male with recurring pyuria and fever. Congenital absence of right kidney and ureter confirmed at surgery. (a) Excretory urogram. Note delayed filling and caliectasis. (b) Two hour delayed excretory urogram. Note dilated ureter measuring 2cm in diameter. (c) Post-voiding cystogram showing urogram trabeculation of bladder and massive reflux. (d) Excretory urogram six months following Y-V plasty on bladder neck and vesicoureteroplasty. Note improvement in caliectasis and marked reduction in the size of reter. (e) Voiding cystourethrogram showing absence of reflux. Note normal appearance of bladder and urethra.



Figure 4-A

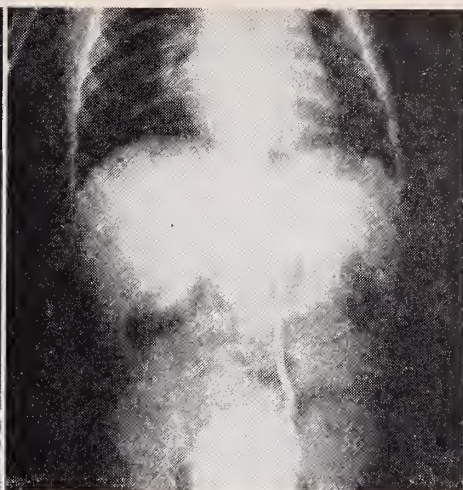


Figure 4-B

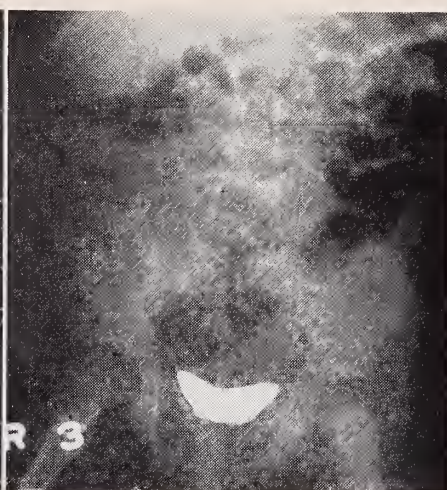


Figure 4-C

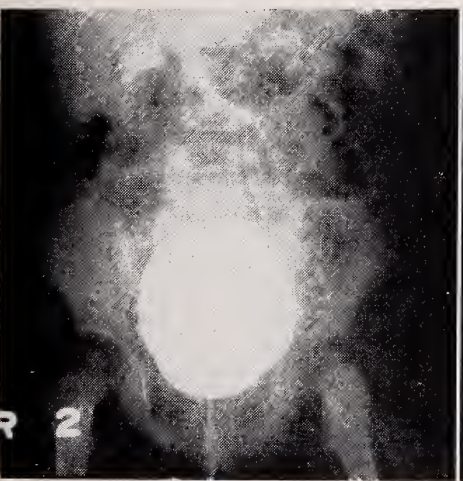


Figure 4-D

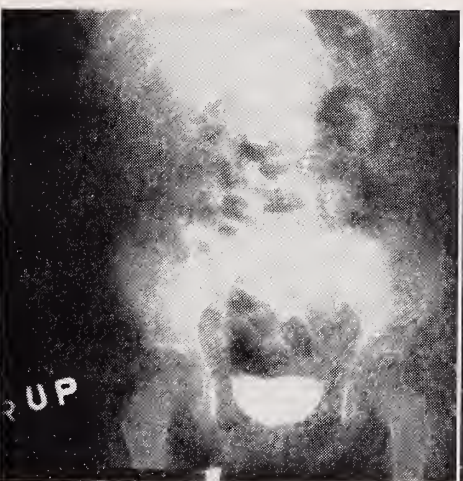


Figure 4-E



Figure 4-F

Figure 4. Fourteen month old white female with recurring episodes of pyuria and fever since age two months. (a) Excretory urogram showing minimal blunting of calices and borderline ureteral dilation. (b) Cystogram showing prompt bilateral reflux. (c) Excretory urogram ten months after conservative management with antibiotics and urethral dilation. Films show some improve-

ment although patient had recurrent fever and pyuria. (d) Cystogram same date as "c" shows prompt reflux bilaterally. (e) Normal excretory urogram nine months following vesicoureteroplasty and revision of bladder neck. (f) Normal cystogram same date as "e." Reflux not present on any of the past-operative cystogram films.

are normal in three-fourths of the children exhibiting reflux. The technique for making cystograms is safe, is quickly and easily performed, and should be done without anesthesia. Cystoscopy may reveal some degree of contracture of the vesical neck and large patulous ureteral orifices. However, cystoscopy may fail to disclose any abnormalities even when marked reflux is present. Surgical techniques are available which may effectively correct reflux. Surgical correction of reflux should be reserved for those children with severe upper urinary tract damage, or those children who fail to improve on conservative management. Reflux is not a rare disorder. If carefully performed cystograms are obtained on all children with unexplained, recurring pyuria and fever;

reflux will be demonstrated in approximately 30 per cent of these children.

Kennestone Hospital, Marietta, Georgia

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CARDIOVASCULAR VOLUME NOW AVAILABLE

The bound volume of MODERN CONCEPTS OF CARDIOVASCULAR DISEASE covering the years 1959-1960 and containing author and subject index is now available at \$3 through the Georgia Heart

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ANTIMICROBIAL-STEROID-TAR COMBINATION* IN TREATMENT OF SUBACUTE AND CHRONIC DERMATOSES

Sidney Olansky, M.D., *Atlanta*

*The combination is more effective than any
of the individual drugs.*

TOPICAL HYDROCORTISONE as an anti-inflammatory agent is clinically well established. However, previously treated areas may become refractory to hydrocortisone alone. Coal tar continues to have value in keratoplastic lesions and as an aid in healing the eczematous dermatoses.¹ However, many patients are unable to tolerate coal tar therapy, especially during the acute stages of severe dermatoses. In spite of their individual effectiveness, neither agent is a satisfactory substitute for the other. Combination of hydrocortisone and coal tar is an attempt to combine and potentiate the best features of each.²⁻⁶

The pruritus frequently associated with eczemas and the resultant scratching often yield clinical or subclinical infection complicating the course of therapy. Clinical observation has proven that these lesions respond better to topical therapy when used in conjunction with an anti-infective agent.⁷⁻⁹ Diiodoquin with its wide antimicrobial spectrum and low sensitivity appears to be of value in controlling the infectious component of secondarily infected dermatoses^{10 11}. The value of a combined diiodoquin-coal tar-hydrocortisone topical combination is the subject of this study.

One hundred and thirteen patients with varied dermatoses were studied. Patients were instructed to use the cream or lotion twice or three times daily. Observation was frequent during the acute phases of the dermatoses and then more widely spaced depending on progress. COR-TAR-QUIN Lotion was particularly useful in hairy areas. The results are shown in Table 1.

*COR-TAR-QUIN Creme and Lotion, Dome Chemicals, Inc., New York, New York.

Table 1					
Diagnosis	Number of Cases	Degree of Response			
		+++	++	+	O
Seborrheic Dermatitis	37	31	6		
Atopic Eczema	16	7	6	3	
Neurodermatitis	41	18	15	7	1
Psoriasis	5	1	4		
Tinea Cruris	3	1		1	1
Hyperkeratosis	3		1	2	
Housewife's Eczema	3	1	2		
Acne-seborrhea	1		1		
Lichen Planus	2	1	1		
Dyshidrosis	1	1			
Pityriasis Rosea	1		1		

KEY

- +++ — Complete control of condition
- ++ — Improvement of condition
- +
- O — No response

Discussion

By comparison with previous clinical experience, the combination of hydrocortisone, tar and diiodoquin appears more effective than any of the medications used alone. The response to the combined therapy was more prompt than noted with hydrocortisone preparations of even much higher concentrations. Many patients who were unable to tolerate coal tar therapy alone, were managed with little to no sensitivity. The preparation was especially effective in seborrheic dermatitis, atopic eczemas and neurodermatitis.

While hydrocortisone preparations are extremely useful in the treatment of many eczematoid, inflammatory and pruritic skin lesions, there appears to be

evidence that this can be very effectively complemented with the keratoplastic action of coal tar and the antimicrobial effect of diiodoquin.

Summary

One hundred and thirteen cases of varied skin diseases were treated with a cream and lotion containing hydrocortisone, coal tar extract and diiodoquin. The results indicate that the combination is more effective than any of the individual drugs. Particularly noteworthy were the beneficial results in seborrheic dermatitis, atopic eczemas and neurodermatitis.

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Dr. Allen Elected AMA Vice President

A GEORGIA PHYSICIAN, Eustace Andrew Allen of Atlanta, has received singular honor and recognition recently in his election to the office of Vice President of the American Medical Association. At the 110th Annual Session of the AMA House of Delegates meeting in New York City, June 25-30, 1961, the Delegates unanimously elected Dr. Allen to this distinguished office. His nomination made by MAG's Delegate to AMA, J. W. Chambers of LaGrange, was seconded by Henry Tift of Macon and some other state delegations. Dr. Allen's term of office runs from June 1961 until June 1962.

He was born in Ashland, Alabama on October 3, 1894. His AB degree was from Birmingham Southern College in 1914 and his MD degree from University School of Medicine College of Physicians and Surgeons in Baltimore, Maryland. He interned at Mercy Hospital in Baltimore and served his residency for the Tennessee Coal and Iron Railroad Company Hospital in Birmingham, Alabama.

Dr. Allen served in World War I and was a member of the Reserve Officers Corps for four years following. He spent two years in medical service for the United Fruit Company in Panama.

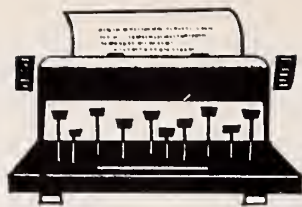
Dr. Allen is licensed to practice medicine in Maryland, Alabama and Georgia. He was Secretary-Treasurer of the Fulton County Medical Society for four years and has served on many committees and as the chairman of several. He is a member of the faculty of Emory University School of Medicine and also is on the active staff of Emory University, Georgia Baptist, and Crawford W. Long Memorial hospitals. He served on the Atlanta Tuberculosis staff for many years. Also he was first Vice President of MAG and has served as chairman of numerous commit-



EUSTACE ANDREW ALLEN, M.D.

tees. He is past President of Health and Hospital section of Metropolitan Community Service and presently is a member of the Planning Division Steering Board of Metropolitan Community Service.

Dr. Allen has been a Georgia Delegate to the AMA for 11 years.



editorials

Congratulations Mr. Vice President

HEARTY CONGRATULATIONS are in order for our new Vice President of the American Medical Association, Dr. Eustace A. Allen. This unanimous expression of confidence by the members of the House of Delegates of the AMA is a fitting tribute to Dr. Allen's 11 years of service as a delegate from the state of Georgia. Not since Dr. James Paullin served as President of the AMA has the state of Georgia

had an officer at the national level.

Only a few years ago Mrs. Allen served with distinction as National President of the Woman's Auxiliary.

Such outstanding service in the interest of organized medicine at the national level by both husband and wife is unique and both are to be congratulated for their contributions.

Metropolitan Atlanta's Fight Against A Polio Threat

THE METROPOLITAN ATLANTA COMMUNITY has recently been the site of two related occurrences of extreme medical interest and importance.

For the first time, in so far as is known, the fortuitous existence of two indications of the prevalence of poliomyelitis virus in the community came at a time when preventive measures could be applied.

In the course of a cooperative study of commercially produced oral vaccine, on which required safety tests for licensure had been completed, the results of examination of stool specimens became available for some 500 children during the first week in June. In a colored housing project and its environs, prevalence of infection with wild Type III polio virus in the sample was found to be 25 per cent. Fifteen per cent of the sample of children in a white housing project and its environs were found to be already infected with this virus. Both of these percentages are several times those that would be expected on the basis of other studies.

At the same time, four clinical cases of polio appeared in the Atlanta area, two of which were known at the time to have been caused by Type III virus. (The other two cases have subsequently been shown to have been caused by Type III virus.)

Either of these factors would have been a matter of concern but coupled together they became real presumptive evidence of an impending Type III poliomyelitis epidemic in the Atlanta area during the summer. The size of such an epidemic could not be projected except by the dangerous device of extrapolation of data gained in other situations. At a minimum, one would expect several times the number of cases experienced in 1960 and, at the worst, such extrapolations could indicate the possibility of several hundred cases.

Faced with these possibilities, the representatives of the Fulton County Medical Society, state and local health departments, and the Communicable Disease Center determined to attempt to prevent

the occurrence of the threatened epidemic by intensive use of Salk polio vaccine. Tentative plans were made in a joint meeting for presenting the need and the opportunity for immunization to the entire public of the metropolitan area. During these few days of planning, it was learned that perhaps Dr. Albert Sabin still had available some of the vaccine which he had tested and used in Cincinnati and various other communities in this country and abroad.

When told of the situation in Metropolitan Atlanta, Doctor Sabin immediately offered from his remaining supply 300,000 doses of Type III oral vaccine for use here as several factors support the choice of oral vaccine under these conditions. Most important among such factors may be mentioned the rapidity of action (significant immunity level within a week), the tendency of oral vaccine to prevent the carrier state, and the ease and rapidity of administration. This suggested, too, the second unusual feature of the recent experience in that this is the first time, so far as can be determined, that oral Type III vaccine has been used in the face of an impending Type III epidemic.

Plans were quickly revamped for the use of both oral and Salk vaccine, the former for those six weeks through 14 years and the latter for protection against

the possibility of Types I and II, as well as for Type III protection of those 15 years of age and older for whom there was not enough Sabin vaccine.

Through the cooperative efforts of the medical societies of the five metropolitan counties, state and local health departments, many volunteer workers, and the unanimous and dedicated news media the campaign was successful, over a period of slightly more than a week, in the immunization of 273,719 children out of approximately 327,000, or 84.4 per cent of the total age group from six weeks through 14 years.

While there have been a few additional cases, and undoubtedly will be more inasmuch as there must have been many children already infected with wild Type III virus at the time of the immunizations, it is anticipated after the expiration of the incubation period there should be few if any additional cases of Type III polio.

This is an outstanding example of total community effort which should not only serve to avoid much crippling illness but also as an example of how communities can apply medical knowledge for the benefit of their individuals.

John H. Venable, M.D.

Director, Georgia Department of Public Health

Closed Chest Cardiac Resuscitation

EVERY PHYSICIAN must learn the technic of external cardiac massage and positive pressure assisted ventilation. Sudden cardiac arrest and death can occur in many clinical situations. It can result accidentally and it can occur for no apparent reason. In either case the situation may be reversible. The arrested heart may still be perfectly normal or capable of maintaining life for many more years. Every physician will sooner or later encounter a situation in which he will be able to reverse "death" if he masters the simple technics involved in closed chest cardiac resuscitation.

This technic was developed and perfected at the Johns Hopkins Hospital after extensive work on laboratory animals. It has now been successfully employed in well over 100 patients, two-thirds of whom were restored to health without evidence of permanent central nervous system damage. Through cooperation with the American Heart Association, a team of instructors has conducted a series of closed

cardiac resuscitation teaching institutes in various sections of the United States including one held in Atlanta in May, 1961. Each who attended one of these institutes agreed to conduct similar institutes in his home community or elsewhere in order to further disseminate this valuable information to physicians. Local teaching institutes can be arranged by communicating with the Georgia Heart Association, 1101 West Peachtree Street, Atlanta 9, Georgia.

The technic consists of massaging or passively pumping the heart by rhythmic pressure applied to the lower one-third of the sternum. This must be accompanied by mouth-to-mouth artificial respiration.

External massage of the heart is possible because of the peculiar anatomy of the human chest. The sternum is attached to the ribs by flexible cartilages. The heart lies between the sternum and the vertebral column. Lateral displacement of the heart is prevented by the pericardial sac. The resuscitator applies his weight to the lower one-third of the sternum

EDITORIALS / Continued

with an extended elbow. The heel of the left hand is placed over the sternum and the right hand applies pressure to the left hand. The sternum is depressed one-and-a-half to two inches at a rate of 60 times per minute. Artificial respiration is given by an assistant at a rate of 12 times per minute. If an assistant is not available, the operator can interrupt the massage every 30 seconds to give two or three respirations mouth-to-mouth.

There are numerous refinements to this basic technic. These have been described in the references listed below. When the cardiac collapse is due to ventricular fibrillation, use of the external defibrillator can be combined with this simple technic and many patients can be successfully resuscitated. Results are far superior to those obtained by open thoracotomy and internal massage.

Every doctor should be prepared to use external cardiac massage and positive pressure assisted ventilation to reverse sudden death caused by electric

shock, myocardial infarction, spontaneous arrhythmias, hypoglycemia, asphyxia, drowning, anaphylaxis, surgical shock, anesthetic accidents, vago-vagal stimulation, and similar clinical conditions. He must also be prepared to use the highest type of clinical judgment in deciding which patients to resuscitate. An ideal candidate would be a child whose heart had stopped because of an accidental electrical shock. A poor candidate would be an elderly patient with advanced carcinoma or multiple myocardial infarctions. Any physician who does not learn this technic will lose a real opportunity to save many lives.

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RATHER BE FREE OR BE SECURE?

ONE OF THE THINGS we hear talked about is freedom. We hear a good deal about free nations and a free world and a free America. We had better talk about it for we today have taken and used the freedom we have received without being either grateful for it or faithful in our use of it.

We have dissipated the heritage we have received. We are losing our freedom in trying to be like everyone else. We crowd together like a bunch of scared cattle, wearing the same clothes, listening to the same programs, afraid to say what we think.

We are losing our freedom by hiding behind government in order to be secure. Sooner or later we must decide whether to be secure or to be free. If we insist on being given security, we can prepare to wear the shackles that go with it.

Government never made anyone free. Free men make a free government. We are losing our freedom because of our love of money. Money never made a man free. No slavery is more complete than that which love of money brings.

Our worship of education can cost us our freedom. Men are saying and writing that education is the foundation of freedom. It is not. It has of itself no power to create freedom. Men use education for their own purposes. Free men created education in this country to enable men to know God. Russia educates that men may ignore God. What matters is not education but what is being poured through it. A system for distributing

water is good if the water is pure and is bad if the water is poisoned.

This country was founded and formed by free men. No government made them free. Government tried to make slaves of them. Money did not make them free. They knew only suffering, privation and danger. Education did not make them free. They created free education because they were free.

They were free men because they knew themselves to be children of God. They had learned what Paul meant when he said, "If Christ shall make you free, ye shall be free indeed." They found that freedom is a matter not of outward circumstances but of inner convictions.

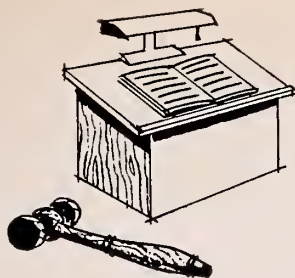
As Jesus stood before Pilate, Pilate was the slave and Jesus was free, free though bound, free even while He died on the cross.

Freedom begins with a man's relation to God. If you would be a free man and if you would serve the cause of freedom here and in the world, you will have to begin at the place of your commitment to Christ as you trust Him for forgiveness and for guidance.

Here and here alone is the source of free government, free business, free education. The distance we have drifted from this conviction in our land indicates how near we are to losing our liberty.

—The Atlanta Constitution

J. M. A. GEORGIA



president's letter



FRED H. SIMONTON, M.D.

"IT'S YOUR HOUSE OF DELEGATES"

THE VITAL LINKS of any organization are as strong as the leadership and certainly no leader can function without good representatives. I believe all of us may be justly proud of our delegates in the Medical Association of Georgia.

I would like to give you a first hand report of the MAG Delegation to the New York meeting of the AMA's House of Delegates. The performance of your representatives at the House of Delegates was, I believe you will agree, democracy in its purest form.

The official Georgia delegation to the House was composed of J. W. Chambers, LaGrange, Henry H. Tift, Macon, Eustace Allen, Atlanta and Alternate Delegate George Dillinger of Thomasville.

Each of these men served faithfully and conscientiously to the end that the doctors of Georgia would have a voice in setting policy of the American Medical Association.

Backing up your official delegates and making themselves always available for any possible assistance they could render were J. G. McDaniel, John T. Mauldin, Carter Smith, Frederick A. Carpenter and Jack Norris of Atlanta, and your President. At the expense of sounding immodest by grouping myself with these men, let me say that each of them

was splendid, all doing yeoman duty throughout the long and sometimes arduous meetings of the House of Delegates and the Reference Committees.

As a working convention, the AMA House of Delegates lost no time in getting down to the business at hand.

Your delegation, official and unofficial, immediately organized themselves into an effective representative body. In the early morning hours before traffic at the busy Pennsylvania Station across the street had yet begun to stir, the Georgia doctors met for breakfast and reviewed each of the 115 resolutions and 28 reports submitted to the House of Delegates the previous day. At this breakfast meeting, a system was worked out to insure that each Reference Committee would be covered by a Georgia physician. Also at the breakfast meeting, prior to departing to the Reference Committees, an official MAG position was adopted for each of the resolutions and reports which would be covered.

At each of the Reference Committees when material presented was pertinent to an official MAG position, Georgia doctors testified freely and effectively. There were numerous comments made by other state's delegates that Georgia covered more territory with fewer people than any other delega-

PRESIDENT'S LETTER / Continued

tion present at the convention. In short, it was a hard working, dedicated and forceful group determined that the doctors of Georgia would have to be reckoned with on all matters deemed important by your delegates and others.

The following morning a second breakfast meeting was held for the purpose of reviewing everything that occurred the day before in Reference Committees. Ambiguously worded resolutions which had been explained in Reference Committees were aired; opinions were gathered on all pertinent issues; all positions taken the previous day were reviewed in light of more detailed information gained at Reference Committees; and strategy was set for the floor fights which were to develop as resolutions and reports were called up for a vote in the House of Delegates.

Immediately following the Georgia breakfast meeting, the House of Delegates met and began its deliberation of the many reports and resolutions. (For a highlight account of the actions taken see "TOP OF THE NEWS This Month").

At the fourth and final meeting of the House of Delegates officers were nominated and elected. J. W. Chambers gave the nominating address for Eustace Allen for Vice President of the AMA. Without attempting to editorialize on either the quality of the address or the candidate, it should be noted that immediately following Chambers' speech a move was made from the floor to end nominations for the Vice

Presidency. In my judgment this speaks well indeed for both Dr. Allen and Dr. Chambers. The election of Dr. Allen has brought both prestige and fame to the Medical Association of Georgia and I know I speak for the Association when I add my personal congratulations to those already received by Dr. Allen.

Henry Tift made a seconding speech in behalf of the nomination of Julian Price of South Carolina for the office of President-Elect of the AMA. However, politics is a fickle art and as difficult to predict as the weather. George Fister of Ogden, Utah was elected to this position. The Medical Association of Georgia wishes him well.

Following a few routine business matters, the 117th Annual Meeting of the House of Delegates of the American Medical Association came to a close. As I stated in the beginning of this report, the conduct of the House of Delegates is democracy at its finest and in my mind will silence for all times the unwarranted and unfounded charge that the AMA does not represent the doctors who comprise its membership. It would do justice to the concepts of the Founding Fathers. Its general demeanor was businesslike. Its deliberation on all matters was thoughtful, thorough and conducted in the best parliamentary tradition.



President, Medical Association of Georgia

REHABILITATION FUNDS ANNOUNCED BY TALMADGE FOR MENTAL HOSPITAL

PRELIMINARY APPROVAL of \$250,000 in federal money to match an equal amount of state funds for equipping a rehabilitation center at Milledgeville State Hospital was received June 26 by the Georgia Department of Public Health.

The 500-bed center, whose building is now under construction at a cost of \$2,479,000 under bids let earlier this year, has been named the Yarbrough Rehabilitation Center after the late Dr. Y. H. Yarbrough of Milledgeville. Dr. Yarbrough was a former superintendent and long-time hospital psychiatrist who remained in service until his death in 1960.

The proposed rehabilitation program will provide both in-patient and out-patient services, according to Dr. John Venable, director of the Georgia Department of Public Health. These services will be in conjunction with the intensive treatment services for which the building was originally designed.

The rehabilitation program, which represents an expansion of the original intensive treatment program plans, is the first comprehensive rehabilitation program to be undertaken by a State Mental Hospital, according to Dr. I. H. MacKinnon, superintendent at Milledgeville. A team composed of physicians, psychologists, social workers, therapists, educators, vocational counselors and psychiatric nurses will work together in interviewing, evaluation, intensive treatment, vocational training, placement and follow-up of discharged patients in the community.

The new Yarbrough Rehabilitation Center will emphasize vocational training and job-finding for patients before and after discharge. The program will be conducted jointly by the Hospital and by the Division of Vocational Rehabilitation, State Department of Education.



THE TREATMENT OF INTRACTABLE ANGINA PECTORIS

Samuel H. Hay, M.D., *Toccoa*

AT PRESENT NITROGLYCERIN is the most effective drug for relieving or preventing the pain of angina pectoris. It must be fresh so that it maintains its potency. The single dosage size must be adjusted up to as high as 1/100 gr. (0.6 mgm) if necessary to achieve satisfactory pain relief. It may be administered sublingually almost as often as necessary. Prophylactic use before anticipated exertion, emotional strain or eating may prevent an attack. When attacks occur frequently, particularly during the night, the effectiveness of a dose may be prolonged by application to the skin of a nitroglycerin containing ointment (Nitrol) as often as every four hours. None of the long acting nitrites is as effective as nitroglycerin. Erythrol tetranitrate (Cardilate) sublingually or buccally is the most effective of this group; doses of from five to 30 mgm every four to six hours may be given. Dosage adjustment, as with nitroglycerin, must be carefully individualized.

The recent manufacture of compact portable units capable of delivering 40 to 100 per cent oxygen by face mask or nasal adapter has added a second immediately available means of increasing oxygen supply to hypoxic myocardial fibers. An increase of the oxygen in physical solution in the collateral circulation in the area of inadequate blood supply theoretically would be beneficial. When used with nitroglycerin for an attack, oxygen does facilitate relief of pain. It is not necessary when nitroglycerin alone is efficacious. The patient may become emotionally dependent on his oxygen supply and this eventuality must be considered before institution of this means of therapy.

There are a number of simple means of reducing the demand for cardiac work which, if successfully

effected, may reverse the previous intractability of a given case. Reduction of weight to desirable normal by dieting is important. Low animal fat diets and triparanol (Mer 29), when cholesterol and lipoproteins are elevated, can very easily be made a part of the diet program although their exact long term benefits have not been delineated yet. Substitution of several small meals for a few larger ones may be helpful. Avoidance of tobacco and its cardioaccelerator effect should be considered. Emotionally upsetting situations should be avoided where possible and mild sedatives or tranquilizers may be used effectively. Recognition of treatment of any infection, gastrointestinal disorders or systemic diseases are imperative for assistance in relief of previously intractable angina. Biliary tract disease is most apt to cause aggravation of angina. Diabetes mellitus must be carefully controlled and hypoglycemia avoided. A comfortable external environment in which temperature and humidity are controlled will be beneficial.

Any one of a number of methods of increasing oxygen supply or of improving myocardial efficiency may prove useful in a given case. Anemia from whatever cause must be repaired. Hypertension should be treated but with caution to prevent the lowering of effective coronary perfusion pressure below a critical level. Arrhythmias, including frequent premature beats, impair cardiac output and should be corrected if possible. In this connection it should be noted that some of the more persistent abnormalities of rhythm may be associated with unsuspected thyrotoxicosis; this should be sought out and remedied.

The most grateful patients will be those who get striking relief from their pains, especially nocturnal pains, when congestive failure even of minimal de-

gree is relieved by the use of digitalis, diuretics and salt restriction. Elevation of the head of the bed may also be beneficial in prevention of pulmonary congestion and concomitant increase of pulmonary arterial pressure.

Since the initial appearance of angina or its sudden increase in severity may result from coronary occlusion without infarction, there is undoubtedly a place for the use of anticoagulants in attempt to prevent extension of the coronary blockage. These cases are difficult to pick out. Frequent small thromboembolic episodes may make angina intractable but may be prevented by use of anticoagulants. It is increasingly evident that there is a place for long term anticoagulant therapy in the management of coronary atherosclerosis because of the improved mortality figures in the treated groups. However, direct observable reduction in frequency or severity of anginal attacks should not be expected with any degree of regularity.

A great many studies are being published heralding the 50 to 70 per cent improvement obtained by administration of monoamine oxidase inhibitors. Few of these reporters have attempted carefully controlled investigations and finally convincing statistics are not

yet available. Through their effect on the psyche or by increase of the pain threshold or by production of postural hypotension or by some other as yet undefined means some relief from anginal pain is manifested in some patients although unaccompanied by objective change in the electrocardiogram. The MAO inhibitors are not as effective as or as free of serious side effects as nitroglycerin.

In the future coronary angiography and coronary thromboendarterectomy will become important diagnostic and therapeutic tools. These techniques are not at present suited to the widespread demand for the relief of one of our most common pain producing disorders. No surgical approach other than direct attack on the diseased coronary artery or its replacement by a suitable prosthesis gives much real promise. Ligation of the internal mammary artery is not a worthwhile operation.

When all other means of relief have failed in spite of three or four months of continuous effort and attention to the smallest details, the production of myxedema by ingestion of radioactive iodine will significantly benefit up to 75 per cent of patients with intractable angina. Two to three months are required for attainment of maximum results. Small doses of thyroid may be necessary to relieve some of the more annoying symptoms of myxedema.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

USE OF HOSPITAL CARE HAS DECLINED

THE ANNUAL USE OF hospital care by the nation's population has declined to the 1940 level of 2.8 days a person, the Health Insurance Institute reported recently.

The average number of days each American spent in general and special hospitals, mental hospitals, and special tuberculosis hospitals was the same in 1959 as in 1940, down after a peak of 3.9 days a person in the wartime year of 1945, and an average of 3.1 days a person in 1951, 1952, and 1953.

The days in hospital per person for the total population was the same for 1940 and 1959 even though hospital admission rates were 75 per cent higher than 20 years ago, the HII said in its report comparing admission rates, lengths of stay, and population figures.

In 1940 there were 74 admissions to general and special hospitals for each 1,000 persons in the population compared to 130 admissions in 1959.

However, advances in medical science helped reduce the lengths of stay in these hospitals, from an average of 13.7 days in 1940 to 9.6 days in 1959. This decrease was the leading reason why the number of days in all hospitals for each 1,000 persons in the population de-

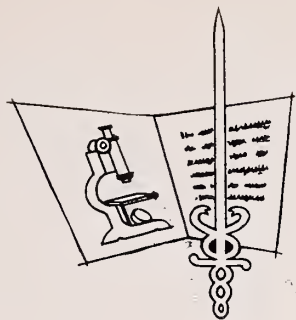
clined from 2,839 days in 1940 to 2,811 days in 1959.

The HII said the reduction in the length of hospital stays played a key role in keeping the demand for hospital services within manageable bounds. If the average length of stay in general and special hospitals had remained at its 1940 level of 13.7 days through 1959, the rise in admissions would have produced 1,789 days in these hospitals for each 1,000 persons, some 43 per cent above the actual figure of 1,254 days.

The toll taken by mental illness in the United States and the long-term aspects of the disease were illustrated by the data. Mental illness has consistently accounted for a minute portion of all hospital admissions, but more than half of the days in hospital.

In 1940, less than two of the 76 admissions per 1,000 population were to mental hospitals but 1,634 of the 2,839 days of hospital stay were in such hospitals. The HII said there was a similar proportion of admissions and patient days in 1959.

Medical science affected a great reduction in days in tuberculosis hospitals, from 185 days per 1,000 persons in 1940 to 140 days in 1959.



cancer page

CYTOLOGIC DIAGNOSIS BY FLUORESCENCE MICROSCOPY

JOHN T. GODWIN, *Atlanta*

WITH THE INCREASING use of cytological studies in early cancer detection, there is a natural desire to improve and simplify the methods in such studies. Many procedures have been tried in an effort to reduce the time and personnel required for cytological studies; such as, interference, and phase microscopy microfluorometric scanning, and mechanical cytanalysis. Up to the present, none has surpassed, in practical application, use of the Papanicolaou technique by a trained Cytotechnologist.

Recently, much interest has been stimulated by the application of the fluorochrome acridine orange, with ultra violet microscopy to cytological studies. This chemical has a strong affinity for nucleic acids. In addition, it has polychromatic qualities, which means the capability of inducing fluorescence of more than one color. After staining with acridine orange, ribonucleic acid (RNA) fluoresces one color and deoxyribonucleic acid (DNA) fluoresces another. RNA is present in the cytoplasm and nucleolus. DNA is present in the nucleus. Acridine orange—DNA combination fluoresces a yellowish-green and acridine orange—RNA combination fluoresces an orange-pink. This, therefore, causes the chromatin material in the nucleus to appear yellowish-green whereas the

cytoplasmic granules and the nucleolus fluoresces orange-pink with the intensity being dependent upon the concentrations of the nucleic acids.

Generally young and fast growing cells have an increased concentration of RNA in the nucleolus and cytoplasm. In atypical and malignant cells, the fluorescence in the cytoplasm and the nucleoli may be brilliant with a flaming red color. In addition, an increase in DNA causes the nuclei to fluoresce a brilliant yellowish-green.

These characteristics would indicate that fluorescence techniques in exfoliative cytology might offer a simple and expedient method of screening.

An effort has been made by several investigators, to determine the efficiency of fluorescence microscopy in the routine screening of cytological material. It has been found that there was no saving of time. This technique requires screening time equal to the Papanicolaou method. Suspicious smears require additional staining, or duplicate smears for Papanicolaou staining must be prepared. Small numbers of well differentiated tumor cells require extreme vigilance to detect as is the case with Papanicolaou stain.

It has been claimed that fluorescence techniques may be used by less skilled personnel. Experience

has shown, however, that one must have as much if not more fundamental knowledge in basic science and cytology to carry out fluorescence microscopy.

Normal cells may exhibit cytoplasmic fluorescence and some well differentiated carcinoma cells may not show this change. A study of sputum and bronchial aspirates demonstrated the sensitivity of fluorescence microscopy to be 4.2 per cent less than that of the Papanicolaou technique.

The statement that a cytological specimen is posi-

tive or negative is a major feat, and it is evident that less training is detrimental to the optimum realization of this tenet.

It appears evident that, in our present state of knowledge, the application of the fluorescence technique to routine cytological studies is not a more rapid or easier screening method than the Papanicolaou procedure. This method may offer an advantage in the study of cells from some locations, however, the final place of fluorescence microscopy in routine use awaits more study of its application at this time.

Approved by Professional Education Committee, Georgia Division, ACS.

NATIONAL PROBLEM OF MENTAL ILLNESS

THE SERIOUSNESS OF THE national problem of mental illness was emphasized on three fronts recently in the nation's capital.

First, the Joint Commission on Mental Illness and Health reported on a comprehensive five-year study of the overall problem. Second, another special government advisory committee recommended smaller community-sized mental institutions after a two-year study of facilities for care of the mentally ill. Third, a Senate subcommittee held hearings on the constitutional rights of mental patients.

The Joint Commission recommended sweeping reforms in the treatment of mental illness as well as expanded and improved facilities. It said some gains had been made in the past 10 years but that the need for adequate facilities for humane, healing treatment of the mentally ill is still largely unmet.

More than half of the patients in state mental hospitals do not receive any treatment, largely because of inadequate facilities, the commission said.

The commission recommended that government spending at all levels—federal, state and local—for public mental patient services be stepped-up in the next decade from the present \$1 billion a year to \$3 billion a year.

Another recommendation was that there be a fully-staffed, full-time mental health clinic for each 50,000 of population.

The commission, which was created in 1955 by a special act of Congress, had 45 members representing

every national association and non-government agency concerned with mental health. The American Psychiatric Association and the American Medical Association had the leadership in setting up the commission.

The government advisory committee, composed of 12 state Hill-Burton and mental health authorities, recommended that states concentrate on smaller community or regional facilities "offering a wide spectrum of services."

Dr. Luther L. Terry, Surgeon General of the Public Health Service, urged state governors to use the advisory committee's recommendations as guidelines for improving mental health facilities.

The Senate Constitutional Rights Subcommittee heard from Dr. Winfred Overholser that there is no foundation to charges that many Americans are "railroaded" into mental hospitals. Dr. Overholser is superintendent of St. Elizabeths Hospital, large federal mental institution in Washington, D. C.

Dr. Lauren H. Smith, vice chairman of the A.M.A.'s Council on Mental Health, told the subcommittee that the A.M.A.'s future program in the field will include emphasis on more use of psychiatry in geriatrics, pediatrics, and medical education, both at student and post-graduate levels.

Other activities planned for the A.M.A. program include closer coordination of activities of the A.M.A. council and corresponding committees of state medical societies.



SYMPTOM REMOVAL

Tom W. Leland, M.D., *Atlanta*

PSYCHOLOGICAL SYMPTOMS which tempt removal by direct attack are those symptoms which seem rather isolated, occurring in what appears to be an otherwise healthy person. Some examples of such symptoms are: "bad habits" (nail biting, smoking, enuresis, etc.), specific phobias or obsessions, conversion symptoms or specific psychosomatic complaints. Before any direct attempt at symptom removal, it is vital to have a fairly clear understanding of what the symptom represents to the patient. Even apparently trivial symptoms serve some function in the emotional homeostasis of the particular individual. Premature attempts at symptom removal (usually detected by the "retrospectroscope") often threaten the patient's emotional economy, for not only is the symptom itself challenged but also any secondary gain that the patient derives from the symptom.

Symptom Removal by Suggestion

Symptom removal by hypnosis is always an intensely powerful intrapersonal experience for the patient. "Cures" are startlingly melodramatic and so are failures. H. Rosen¹ states, "Unless the hypnotist has had adequate training in psychodynamics, hypnosis may be extremely dangerous for his patient without his knowing it." The technique of hypnotic induction can be easily learned in 30 minutes, and in many ways it is unfortunate that it is so simple technically. Hypnosis, no matter how gentle the in-

duction, is a somewhat forced transference relationship. Many suggestible patients become panicked or confused at the sudden emergence of their child-like feelings. The "magic" of hypnosis for some becomes a long pursued license to regress, which may tend to "fix" the dependency of the subject onto the hypnotist.

When an isolated symptom persists with unexpected tenacity one should keep in mind the possibility of a monosymptomatic psychosis. Here, the presenting symptom may be compared to a seemingly "small" meningioma nine-tenths of which, like an iceberg, is buried in vital tissues and which will require a major surgical effort with significant sequellae to be expected.

Symptom Removal by Repression

Probably for the majority of patients who "go to the doctor" the non-probing technique of interviewing is rather expected by the patient. For some, however, the presenting physical complaint is a self-induced subterfuge. It's not the throbbing headaches but rather the throbbing fears and gnawing self doubts that are the real chief complaints. Anamnesis with such a patient requires finesse if he or she is to return but not return "too frequently." Many busy physicians tend to suppress their patient's emotional history. For many patients this "avoiding the subject" may be reassuring in itself. For others, it is not, they want to discuss their nervousness, fears and doubts.

Prescribing tranquilizers may be a repressive technique in itself, especially when the tranquilizers are given with an implied, "This will get rid of your complaints (and complaining)." Occasionally tranquilizers increase anxiety — especially when the anxiety is already partially due to excessive repression. With these latter patients, increasing the dosage or changing the brand of drug is either of very brief benefit or actually continues to increase the anxiety. The patient at this stage of the process may begin a game called "doctor shopping," carrying to each new physician their mounting defensiveness and increasing symptomatology.

Symptom Removal by Relationship

As avoiding the question of nervousness of temporarily repressing the anxiety with drugs is not the answer, neither is carte blanche reassurance. Anxiety like dental caries is an "abnormality" that is statistically "normal." Anxiety has positive as well as negative values. The patient may need to know that the tension and anxiety are symptoms heralding some change that is going on from within and that the change may be a step toward more maturity. It is frequently helpful for some patients to know that their physician is aware that they are neurotic, that he knows this, and yet is still going to work with them. A useful approach, well worth studying, is a technique called support through non-reassurance.² It might be quite supportive, for example, to let the patient know that his symptoms are not unlike

"growing pains" and that his efforts at "growth" should not be sidetracked by suppressing the symptoms. A few sleepless nights working on a problem and getting at it can be cheaper in the long run than six months on barbiturates trying to repress the symptoms out of awareness. This type of frank non-reassurance is usually most effective only after the patient has had several chances to ventilate his problems and most important, that the patient has some definite feeling of a lasting relationship developing with the physician. It is this feeling of an enduring relationship with the doctor that "allows" rather than "forces" symptom removal.

Intensive or uncovering psychotherapy is of curative value in selected cases. In many ways it may seem to be the round-about approach at symptom removal. Some psychiatric patients do indeed lose their symptoms in the early stages of psychotherapy (flight into health), and on rare occasions there is a "one interview cure" (jet flight into health). Here, the symptoms that have vanished have, of course, merely gone underground, and whether or not the patient stays in or drops out of treatment the symptoms will recur. With intensive psychotherapy, as it is with supportive psychotherapy, the symptoms typically persist for some time and are only gradually relinquished.

REFERENCES

1. H. Rosen, M. D., "Hypnosis—Applications and Misapplications," *J. of Amer. Med. Assn.*, Vol. 127, pp. 683-687, Feb. 13, 1960.
2. J. Warkentin, M. D., "Support Through Non-Reassurance," *Amer. J. of Psychotherapy*, pp. 709-715, 1956.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

BLUE SHIELD ENROLLMENT INCREASES

ENROLLMENT IN THE nationwide Blue Shield Plans surpassed the 47,000,000 member mark at the end of 1960, the National Association of Blue Shield Plans reported in Chicago recently. Total membership in the 74 medical-surgical plans reached 47,084,988 on December 31, 1960, representing an enrollment of one out of every four Americans, and nearly 15 per cent of the total Canadian population.

The net gain in membership for 1960 amounted to 2,292,065, the national association noted in its year-

end report. The national Blue Shield totals for the first time included the membership of Surgical Service, Inc., Albuquerque, New Mexico and Physicians Service, Providence, Rhode Island, who were approved as active members of the National Association of Blue Shield Plans last year. The combined year-end enrollment of these two new Blue Shield Plans was 659,240 members. Also included in the enrollment figures were federal workers who selected Blue Shield under the Federal Employee Health Benefit Program in 1960.



physician's bookshelf

BOOKS RECEIVED

Goth, Andres, M.D., *MEDICAL PHARMACOLOGY, PRINCIPLES AND CONCEPTS*, The C. V. Mosby Co., St. Louis, 1961, 551 pp., \$11.00.
Vass, C. C. N., *A SYNOPSIS OF PHYSIOLOGY* (Rendle Short), The Williams and Wilkins Co., Baltimore, 1961, 348 pp., \$8.00.
Alonso, Martinez E., M.D., *MEMOIRS OF A MEDICO*, Doubleday & Company, Garden City, New York, 1961, 335 pp., \$4.50.
Rule, Colter, M.D., *A TRAVELER'S GUIDE TO GOOD HEALTH*, Dolphin Books, Doubleday and Co., Garden City, New York, 240 pp., \$.95
Roper, Nancy, *OAKES' DICTIONARY FOR NURSES*, Williams & Wilkins Co., Baltimore, 1961, 492 pp., \$2.75.
Wolstenholme, G. E. W. and Cameron, Margaret P., *CIBA FOUNDATION STUDY GROUP NO. 7, VIRUS MENINGO-ENCEPHALITIS*, Little, Brown and Company, Boston, 120 pp.
Wolstenholme, G. E. W. and O'Connor, Cecilia M., *CIBA FOUNDATION SYMPOSIUM ON QUINONES IN ELECTRON TRANSPORT*, Little, Brown and Company, Boston, 453 pp.

REVIEWS

Vane, J. R., Wolstenholme, G. E. W. and Maeve O'Connor, *ADRENERGIC MECHANISMS, CIBA FOUNDATION SYMPOSIUM*, Little, Brown and Co., Boston, Mass., 1960.

THE 632 PAGES of this text represent the very productive culmination of a symposium on adrenergic mechanisms that was held in England on March 28-31, 1960.

The participants in this symposium have all made considerable contributions in this area of research. Some 50 papers were presented which dealt with the nature and activity of the adrenergic transmitters from their formation to their inactivation. The material presented was very wide in scope ranging from investigations of adrenergic mechanisms at the cellular level to therapeutic applications in man. Included in this text is the spontaneous discussion that followed the presentation of each paper which in many instances was just as interesting as the paper that preceded it. The subject is approached from a biochemical, a pharmacological,

a clinical and even an historical point of view. Included in the text also are numerous figures and tables presented by the various investigators.

This text is of special value to the research worker in any of the many areas of research covered. However, by no means is this text restricted only to the research worker. This text represents a comprehensive compilation of our understanding of adrenergic mechanisms with all of its clinical implications. Therefore, this text may be read, fruitfully, by anyone whether he be a basic biological scientist, a clinician or a general practitioner.

Bernard Levy, M.D.

Beckman, Harry, M.D., *PHARMACOLOGY*, W. B. Saunders Co., Philadelphia, Pa., 1961, 805 pp., \$15.50.

THIS SECOND EDITION of a pharmacology textbook is primarily intended for the undergraduate medical student. The reviewer nevertheless heartily welcomes this edition as a much-needed source of reliable information about drugs.

The book, which contains 805 pages, is divided into three sections. The first two sections provide a description of the background of pharmacology as a science. The third section, which comprises the major part of the text, takes up the actions and uses of drugs.

The arrangement of topics in the third section provides for accessibility of the information in terms of clinical problems encountered. The fact that one author covers the material lends desirable continuity of style to the whole work.

Dr. Beckman's writing comes to life with a pleasing conversational manner of writing which is unexpected. The readability is an extra dividend especially welcome in a textbook.

The reviewer would have benefited from a text such as this as a medical student and recommends this text to any who may have need of a pharmacology textbook.

Benjamin D. Saffan, M.D.

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

PHYSICIAN'S BOOKSHELF / Continued

Willson, J. Robert, M.D., *ATLAS OF OBSTETRIC TECHNIC*, The C. V. Mosby Co., St. Louis, Mo., 1961, 304 pp., \$14.50 (de luxe) and \$12.50 (regular).

THIS ATLAS GIVES to the obstetrician a detailed and complete picture visualization of all the obstetrical operative procedures done at term. It should be in every delivery room suite for quick reference, for often long periods of time elapse between the need for these procedures.

The first chapter is devoted to the philosophy of the progressional staff and the facilities of the labor room and delivery. This is the only part of the book which could be deleted.

Beginning with Chapter II, entitled "Normal Labor and Delivery," and ending with Chapter XIV, entitled "Craniotomy," the reader is treated to a brief but accurate and interesting outline to all the complications of term pregnancy. Very complete and easy to understand illustrations accompany each subject.

It is a must for delivery room suites.

Joseph L. Girardean, M.D.

Committee on Trauma, American College of Surgeons, *THE MANAGEMENT OF FRACTURES AND SOFT TISSUE INJURIES*, W. B. Saunders Co., Philadelphia, Pa., 1960, 372 pp., \$5.00.

THIS 359-PAGE HANDY sized book combines the revised and rewritten Fracture and Soft Tissue Care Manuals previously published by the American College of Surgeons. The subject material covers all phases of the care of traumatic soft tissue and bony injuries correlating and emphasizing basic principles with specific recommendations for treatment.

Words have not been wasted in this "manual" and the "pearls" are evident. Being a product of the Committee on Trauma of the A.C.S., the caliber of instruction is superior throughout.

There are five individual chapters dealing with shock, burns, head, neck, abdominal, G-U and chest injuries, etc.; as well as a chapter on care of the patient with multiple injuries.

The outline on infection, especially as concerned with clinical differentiation and treatment of clostridial myositis and cellulitis is most informative and the addition of a chapter on the treatment of bites is welcome.

I recommend this book with enthusiasm to all house officers, medical students and practitioners who deal with acute trauma—and that includes most all of us.

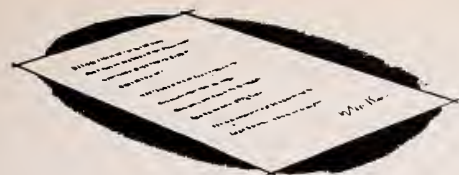
Joseph H. Dimon, M.D.

Reminding All General Practitioners of the

13th Annual Session of the **Georgia Academy of General Practice**

Aquarama, Jekyll Island, Georgia

October 12-14, 1961



Hock, Charles W., M.D., 1467 Harper Street, Augusta, Georgia, "Medical Treatment of the Functionally Ill Geriatric Patient," *Geriatrics* 16:182-184 (April) 1961.

The elderly patient must receive kindness and consideration from his physician as well as a thorough medical evaluation. Tender loving care should be the keynote of treatment. Anabolic therapy (Durabolin®) is frequently helpful for restoration of the functionally ill geriatric patient to a healthier, more productive life. If a thorough job is done and the whole patient is treated, much can be accomplished.

The treatment of elderly patients with functional disease must be symptomatic, which is now possible with the large array of drugs at our disposal. The anabolic steroids not only exert a tissue-building effect but also help to induce a change of mental attitude from apathy to psychic vigor and vitality.

Of the 50 cases studied, the majority required two cc. of Durabolin® every seven days for relief of symptoms. Routine dosage was two cc. until the patient experienced good response and then the dosage was decreased. A good to excellent relief from symptoms of weakness, poor appetite, sleeplessness, nervousness, and lack of energy was noted in 74 per cent of the patients. Mild side effects were reported in only eight patients.

Smith, R. H., M.D.; Gramling, Z. W., M.D., and Volpitta, P. P., M.D. Medical College of Georgia, Augusta, Georgia, "Problems Related to the Prone Position for Surgical Operations," *Anes.* 22 (March-April) 1961.

In an effort to improve patient care, we sent 225 form letters to the anesthesiology residency teaching centers in the United States, asking for information on their methods of placing patients in the prone position. One hundred sixty-five were received and analyzed, and it became apparent that the basic requirements for the comfort and safety of the patient in the prone position needed clarification. We tested an obese and an average weight male and female for their reactions to the various

methods recommended in the 165 replies, then we tested the physiological responses of several anesthetized patients to the recommended methods.

It was learned that in the anesthetized patient, any position was satisfactory if there was no interference with abdominal movement or venous return from the lower part of the body.

It was learned that intra-operative discomfort was avoided in the awake patient, and postoperative pain was prevented in the patient who had had general anesthesia, if a few principles were observed. These follow:

1. The abdomen must be perfectly free to move with respiration.
2. The patient's weight can rest on his chest wall and anterior superior iliac spines, and leave the abdomen free to move. The chest support is best made of a firm, flat, table-wide padding.
3. The patient's back and neck must be in the same plane so rotation of the head to either side occurs at the axis joint. It is necessary to elevate the chest and the pelvis the same amount, to keep the back and neck on the same plane.
4. The patient prefers to have his arms stretched "above head," instead of on arm boards.
5. The female lies between her breasts. The breasts are pulled out laterally.
6. Spot pressure under the sternum and infraclavicular fossae is very painful. These are poor support areas.
7. Obstruction to venous return at the femorals or inferior vena cava increased blood loss from venous oozing during low-back surgery.

A new position for low back surgery is described. It has been used repeatedly with good results. It is difficult to achieve, but appears to be worth the trouble.

Dimon, J. H. III, M.D., 1938 Peachtree Road, N.W., Atlanta, Georgia, (From the Fracture Clinic of the Mass. Gen. Hosp., Boston), "Isolated Displaced Fracture of the Posterior Facet of the Talus," *J. Bone & Joint Surg.* 43-A:275-281 (March) 61.

The author reports three cases of isolated displaced fracture of the posterior facet of the talus and emphasizes the fact that this fracture can occur and be clinically indistinguishable from a simple sprain of the ankle initially. Careful inspection of the roentgenograms usually enables the diagnosis to be made, and when in doubt, oblique views of the ankle are indicated. Two cases in which the diagnosis was not appreciated initially subsequently went on to show narrowing and sclerosis with arthritis of the subtalar joint and persistent disability and pain. A third case in which the diagnosis was made initially and in which open reduction was carried out showed an essentially normal foot thirteen months after surgery. It is suggested that isolated displaced fracture of the posterior facet of the talus always be suspected in any ankle injury, and it is suggested that perhaps an open reduction and internal fixation are indicated when there is a displaced fracture of the posterior facet of the talus.

Dobes, W. L., M.D., 478 Peachtree Street, N.E., Atlanta 8, Georgia, "New 'Inject-tainer,'" *Arch. Dermat.* 83:847 (May) 61.

A new "Inject-tainer" is described to speed up injections and safeguard one's needles. The needles cannot become burred because they are suspended by the hub, with the point hanging down into the container. No forceps are needed for removal. One presses the syringe down into the hub of the needle and turns it clockwise. This locks the needle to the syringe. The needle can easily be removed again in the same manner. Each container contains up to 36 needles. Container and needles can be sterilized simultaneously. A sufficient and quick supply of sterile needles is made easily available. The "inject-tainers" are available through surgical supply houses.

ABSTRACTS / continued

Dickson, Harry E., M.D., Department of Public Health, Atlanta, Georgia, "The Management of Hypertension and 'Low Blood Pressure' in the Employee," *Indust. Med. & Surg.* 30:195-199 (May) 61.

In the field of Occupational Health as a part of its program in the prevention of diseases it behooves the industrial employer to institute an effective program of early detection, counseling, referral to the private physician, and follow-up of all employees with consistently elevated blood pressures. The fact that there is no specific etiology of hypertension complicates a control program as well as statistical analysis of the response of a group of hypertensive employees.

Among 3,930 employees screened in the Georgia State Employees' Health Service over a four year period, an over-all prevalence of 8.3 per cent hypertensives was found. These em-

ployees were referred to their private physicians for evaluation. Of this number 38.7 per cent were overweight. The article describes how these employees were studied, counselled, and the results obtained in this preventive program.

Criteria are discussed concerning the work restrictions that should be placed on the severely hypertensive industrial employee.

The frequent diagnosis of "low blood pressure" among female employees is discussed. There is no such disease entity, the article states. Counseling cautiously is the only way to dispel this "old wives" tale. In a few instances, postural hypotension may be the case, but this condition is not too prevalent among the industrial population.

The Clubfoot Problem in Achondroplasia," Kite, J. Hiram, M.D., "Achondroplasia: Southern Medical Journal 54:577-583 (June) 61.

Achondroplasia is a disease of the skeleton in which the formation of bone from cartilage is retarded, but the formation of bone from the perios-

teum is not. The longitudinal growth of the bones is diminished, but the peripheral growth is normal. The bones of the arms and legs appear to be short and thick. The delayed growth at the ends of the bones accounts for the shortening and also accounts for the bowing and other deformities.

A review has been made of 18 achondroplastic children and the clubfoot problem in four discussed. The clubfoot deformity in these four achondroplastics is different from the average clubfoot deformity. The equinus element is more marked. The talus is displaced forward out of the ankle mortise and the posterior surface is flat and square. The middle three metatarsals are curved. These achondroplasia clubfeet were very stiff and correction was difficult. The deformity could not be corrected in a brother and a sister. They may present a pattern of their own, or this unusual pattern as exhibited in these four patients may be typical of clubfeet in achondroplasia.

Fulton County Meets Serious Polio Threat

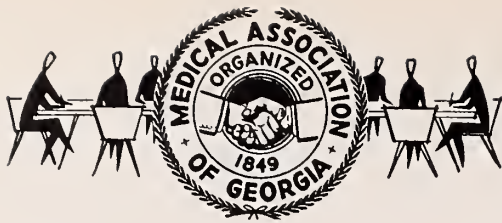


Pictured above are some of the 2,585 children who received Sabin and Salk vaccine at Fulton County Medical Society's Academy of Medicine in Atlanta, between June 22-29. The Sabin vaccine was a gift of Albert B. Sabin, M.D., of the Children's Hospital in Cincinnati, Ohio, and was flown here during Atlanta's serious polio threat in June.

The upper left picture is of a little girl taking her Sabin vaccine in a sugar lump; upper right and lower left are little boys getting their Salk vaccine with a jet injector hypodermic spray; and lower right is a little fellow getting his Sabin vaccine in liquid form in a teaspoon. Fulton County residents could get this vaccine at the Clinic in the Academy of Medicine and 24 Fulton County Health Centers.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Anderson, Robert H., Jr.	Gold Street Gainesville, Ga.	Active	Hall
Beard, Carl L.	1540 Watson Blvd. Warner Robins, Ga.	Active	Peach Belt
Bivins, Blake S.	Beech Street Cochran, Ga.	Active	Ocmulgee
Brannon, Dabney H.	35 Linden Ave. Atlanta 8, Ga.	DE-2	Fulton
Brown, Coleman M.	Emory Univ Clinic P. O. Box 459, Atlanta 22, Ga.	Active	Fulton
Bullard, J. Roger	103 S. Main St. Acworth, Ga.	Active	Cobb
Davis, Donald F.	1953 Seventh Ave. Columbus, Ga.	Active	Muscogee
Douglas, George W.	Communicable Disease Center Atlanta 22, Ga.	Service	Fulton
Elliott, Mary H.	2932 S. Atlanta Road Smyrna, Ga.	Active	Cobb
Fine, Robert M.	356 W. Ponce de Leon Decatur, Ga.	Active	DeKalb
Gordon, James H.	Toombs County Health Dept. Lyons, Ga.	Active	S. E. Ga.
Harrison, Charles E., Jr.	Box 223, Grady Mem. Hospital Atlanta 3, Ga.	DE-2	Fulton
Jessen, Ronald C.	1968 Peachtree Road, N.W. Atlanta 9, Ga.	Active	Fulton
Lindsey, Francis M.	33 Chestnut Street Elberton, Ga.	Active	Franklin-Hart-Elbert
Naiman, Richard A.	80 Butler Street Atlanta 3, Ga.	DE-2	Fulton
Noble, William A.	80 Butler Street Atlanta 3, Ga.	DE-2	Fulton
Redd, Stephen S.	80 Butler Street Atlanta 3, Ga.	DE-2	Fulton
Richman, Gary O.	1968 Peachtree Road, N.W. Atlanta 9, Ga.	DE-2	Fulton
Simpson, Harvey L., Jr.	314 N. Westberry Sylvester, Ga.	Active	Worth
Thrasher, Barrie H., Jr.	80 Butler St., S.E. Atlanta 3, Ga.	DE-2	Fulton
Wright, Ashbury D., Jr.	221 Northside Drive Gainesville, Ga.	Active	Hall



the association

DEATHS

CHARLES HENRY BLOODWORTH, JR., 34, of Decatur died June 21 at Lake Sinclair. Dr. Bloodworth was born in Winnsboro, S. C. and was educated in North Carolina and Macon. He was a graduate of the Citadel and the Medical College of Georgia. He served his internship at Macon Hospital and his residency at Grady Memorial Hospital in Atlanta. He was a diplomate of the American Board of Surgery and was engaged in the practice of general surgery for one and one-half years in Atlanta.

Dr. Bloodworth was a member of the Clairmont Hills Baptist Church in Decatur, a member of the American College of Surgeons, the Fulton County Medical Society, the Medical Association of Georgia, the American Medical Association and the Phi Chi Medical Fraternity.

Surviving are his wife, the former Miss Thelma Sibberns of Decatur, a daughter, Rebacca Ann; two sons, Charles Henry III, and Thomas; his parents, Mr. and Mrs. Charles H. Bloodworth, Sr., of Macon; a sister, Mrs. Jack W. Jenkins, Albany; and several nieces and nephews.

Anesthesiologist **PIERRE CHARLES HERAULT, JR.**, 47, of Columbus, died in a LaGrange hospital on June 14, 1961.

Dr. Herault graduated from Emory University and Emory University School of Medicine. He did his internship at Piedmont Hospital in Atlanta and his residency at Grady Memorial also in Atlanta. Before going to LaGrange to practice Dr. Herault was in New Orleans. He was a member of the Troup County Medical Society, the Medical Association of Georgia, the American Society of Anesthesiologists, and the First Presbyterian Church in Atlanta.

He is survived by his wife, the former Miss Laura McGowan; a daughter, Pamela; a son, Pierre Charles, III; and his mother, Mrs. Laura Reid Herault, of Atlanta.

SOCIETIES

The Executive Committee of the **BIBB COUNTY MEDICAL SOCIETY** voted at their June meeting to

help the ministerial society purchase a piano for the Chapel in the Macon Hospital.

The **CRAWFORD W. LONG MEDICAL SOCIETY** is continuing their series of articles in the *Athens Banner-Herald*, answering letters and telling of important happenings of the profession.

The **FLINT COUNTY MEDICAL SOCIETY** sounded their position on aid to the Aged through their president Woodrow Goss recently in an interview for a local newspaper.

The **FULTON COUNTY MEDICAL SOCIETY** sponsored an intense campaign to immunize Fulton County against Polio, Types I, II, and III, while there was a threat in Atlanta of an epidemic.

The **GORDON COUNTY MEDICAL SOCIETY** invited H. Richard Connell, Jr. of the Harbin Clinic in Rome to present a paper on "Endolymphatic Hydrops" at their June meeting.

The **HALL COUNTY MEDICAL SOCIETY** is making plans for the Hall Health Fair to be held Oct. 11 and 12 at the Civic Building.

The **JEFFERSON COUNTY MEDICAL SOCIETY** at their June meeting had a program on "The Cancer Detection Examination."

A resolution requesting state funds together with federal matching funds to begin an indigent care program has been sent to Governor Vandiver by the **RICHMOND COUNTY MEDICAL SOCIETY**.

The **WALKER-CATOOSA-DADE MEDICAL SOCIETY** held their May meeting at the Fairyland Club, Lookout Mountain. They planned to incorporate the society at that meeting.

PERSONALS

First District

The Georgia Heart Association's First District Chapter elected officers recently in Savannah. Re-elected to the board of directors were: J. MILLER BYNE, JR., Waynesboro; JOSEPH YATES, Soperton; CURTIS G. HAMES, Claxton; and a new member of the board, JOHN R. HARRISON, Millen.

KATRINE R. HAWKINS attended the AMA meeting in New York accompanied by Mr. Hawkins.

PETER SCARDINO, urologist, of Savannah was re-elected as President of the Savannah Symphony Society and also received the Thomas H. Gignilliat award in the field of culture. He was one of four outstanding citizens named for 1960 by a panel of 16 civic club presidents.

JULIAN QUATTLEBAUM, JR., surgeon, became the second Board qualified Thoracic Surgeon in Savannah in May.

GABRIEL D'AMATO of Savannah has accepted a position at the Medical College of Georgia in Augusta. His duties begin in September as associate professor in psychiatry.

Second District

Sylvester is the town where HARVEY LEE SIMPSON, JR. opened his office in June. He confines his practice to medicine and general surgery.

Third District

JACK C. HUGHSTON, orthopedic surgeon, is the new chief of staff at the Medical Center in Columbus. Other officers elected were WILLIS P. JORDAN, chief-elect for 1962 and ROBERT M. FLOWERS, secretary.

Fourth District

No news submitted.

Fifth District

J. FRANK WALKER, Atlanta, is the Immediate Past President of Peachtree Civitan Club and Lt. Governor of Georgia District North Civitans.

LESTER A. BROWN of Atlanta announces that he is limiting his practice to Otology.

WILLIAM F. FRIEDEWALD, A. H. LETTON, J. G. McDANIEL, and JOHN VENABLE were on a panel to answer questions about polio on WSB radio June 25. The group discussed the Sabin and Salk vaccines, the possibility of a serious epidemic and the nature of viruses.

SAMUEL P. TILLMAN has opened his office in Statesboro for the practice of internal medicine and cardiology.

Sixth District

No news submitted.

Seventh District

DON SCHMIDT of Cedartown who served as president for the Cedartown Lions Club for two years, has been elected district governor for District 18-A.

C. V. TANNER of Douglas opened offices in Pearson Clinic which is city owned.

Eighth District

G. W. BARKER and REX STUBBS, have announced their partnership association. Their offices are in the St. Marys Clinic on Dilworth Street in St. Marys.

RALPH A. TILLMAN of Pearson is now in Atlanta studying obstetrics and gynecology at Georgia Baptist Hospital.

Ninth District

BEN LOOPER of Canton is the President of the Canton Lions Club for the coming year.

RALPH H. CHANEY took leave of absence from the Medical Arts Clinic in Toccoa to study anesthesiology at the Medical College of Georgia in Augusta during July.

FAYETTE SIMS of Lawrenceville was recently selected by the home town newspaper as the "Citizen of the Week."

BRUCE SWAIN of Clarkesville has opened offices in Cornelia. His office will be that formerly occupied by BRUCE J. ROBERTS who is now practicing in Macon.

ROBERT ANDERSON has opened offices in Tifton for the practice of general surgery.

Tenth District

The Wilkes County Hospital Authority recently announced that in the new hospital the North wing will be named the Simpson Wing in honor of A. W. SIMPSON and the South wing will be known as Nash Wing in honor of the late THOMAS NASH.

ROBERT B. GREENBLATT of Augusta spoke recently to the eighth annual Mountaintop Medical Assembly in Waynesville, N. C. on hormones and cancer.

The Medical College of Georgia recently announced faculty promotions for the year 1961-1962. MAG members include: FLOYD E. BLIVEN, Professor of Surgery (Orthopedics); JOHN R. FAIR, Professor of Surgery (Ophthalmology); FRANK P. ANDERSON, Associate Professor of Pediatrics; HAROLD S. ENGLER, Associate Professor of General Medicine; ENON C. HOPKINS, Associate Professor of Medicine; JAMES A. KEMP, Assistant Professor of Medicine; WINFORD H. POOL, JR., Assistant Professor of Radiology; IVERSON BRYANS and WILLIAM THURMOND, Clinical Professors of Obstetrics and Gynecology; WILLIAM S. BOYD, JOHN PERSALL, and WALTER G. WATSON, Associate Clinical Professors in Obstetrics and Gynecology; and GORDON WALTERS, Clinical Instructor in Medicine.

MAG EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE JUNE MEETING of the Medical Association of Georgia Executive Committee of Council was called to order by President and Chairman Fred H. Simonton at 8:15 P.M., on June 9, 1961 at the MAG Headquarters Building, Atlanta, Georgia.

The members of the Committee present were: Fred H. Simonton, Chickamauga, President and Chairman; Thomas W. Goodwin, Augusta, President-Elect; George H. Alexander, Forsyth, Chairman of Council; Milford B. Hatcher, Macon, Immediate Past President; John T. Mauldin, Atlanta, Secretary; and J. G. McDaniel, Atlanta, Chairman of Finance. Also present were Edgar Woody, Jr., Atlanta, Editor, JMAG; Mr. Richard Nelson, AMA Field Representative; Mr. Milton D. Krueger, Executive Secretary; Mr. James M. Moffett, Asst. Executive Secretary; and Mrs. Catherine Wooten, Executive Assistant.

Chairman Simonton asked President-Elect Goodwin to give the invocation.

The minutes of the Council meeting of May 6 and 10, 1961, and the Executive Committee meeting of May 10, 1961 were read by Mr. Krueger. On motion duly made and seconded the minutes were approved as read.

State Medical Journal Advertising Bureau Stockholder

Edgar Woody, Jr., Editor, JMAG, gave the Executive Committee background information on the above organization. On motion (McDaniel-Alexander) it was recommended that Council authorize \$200.00 for the purpose of becoming a stockholder; and it was recommended that President Simonton present this to Council. Executive Committee so voted to accept this recommendation.

Georgia Veterinary Medical Association Request

Secretary Mauldin gave a report on the recent meeting of the Interprofessional Council regarding representation of the Georgia Veterinary Medical Association on the Interprofessional Council. It was recommended that a letter from the President be written the MAG representative on the Interprofessional Council that MAG looked with favor on the admission of the GVMA to the Interprofessional Council.

Vocational Education Program for Training Hospital Housekeeping

Supervisors

Secretary Mauldin read a letter from Mrs. Fannie Mae Walker, State Supervisor of Practical Nurse Education, State Department of Education, regarding the above program. There was general discussion on this subject. On motion duly made and seconded it was voted to ask Past President Hatcher to obtain further information and report to the next Executive Committee meeting. Dr. Hatcher requested that copies of Mrs. Walker's correspondence be sent to him.

Ministerial Liaison Committee Recommendations

Mr. Milton Krueger read a letter from Dr. Needham B. Bateman, Chairman of the Ministerial Liaison Committee, requesting permission to send an all member mailing on the aims and functions of his committee. It was recommended that an editorial by Dr. Bateman be written for publication in the JOURNAL in view of the fact that this was a non-budgeted item. On motion (Hatcher-Alexander) it was so voted.

Request for Endorsement of Project of Georgia Conference on Social Welfare Meeting

Secretary Mauldin read a letter requesting endorsement of this meeting. He stated that endorsement of a similar meeting had been rejected last year by MAG. On motion (Mauldin-Hatcher) it was voted to instruct the Secretary to write this organization that it is not the policy of MAG to endorse programs of this nature. However, the President would designate three members to attend as MAG representatives, with instructions to the Chairman of these representatives to report to Council after each meeting.

Request for Endorsement of Project of Georgia Occupational Health Service

Secretary Mauldin read a letter asking for endorsement of "A Guide for Providing Occupational Health Services for Agricultural Pursuits" requested by the Director of Occupational Health Service of the State of Georgia. On motion duly made and seconded it was voted to instruct the Secretary to write the Director of Occupational Health Service that this was being referred to the MAG Board of Occupational Health for investigation.

Confirmation of Workman's Compensation Medical Board Appointments

Secretary Mauldin asked for recommendations for appointments to the Workman's Compensation Medical Board, as requested by Governor Vandiver, and those suggested were as follows:

- A. P. Jones, M.D., Griffin, Georgia (Internist)
- Floyd Sanders, M.D., Decatur, Georgia (Internist)
- Warren B. Matthews, Marietta, Georgia (Pathologist)
- Warren B. Matthews, M.D., Marietta, Georgia (Pathologist)
- G. Lester Forbes, M.D., Atlanta, Georgia (Pathologist)
- Jack C. Norris, M.D., Atlanta, Georgia (Pathologist)
- Hugh Hailey, M.D., Atlanta, Georgia (Dermatologist)
- David L. Hearin, M.D., Atlanta, Georgia (Dermatologist)
- Duncan Shepard, M.D., Atlanta, Georgia (Surgeon)
- Richard L. Smoot, M.D., Decatur, Georgia (Surgeon)
- Albert A. Rayle, Jr., M.D., Atlanta, Georgia (Radiologist)
- W. C. Coles, M.D., Atlanta, Georgia (Radiologist)

On motion duly made and seconded it was voted to accept the above named and to bring the recommendations to Council for approval; Executive Committee also voted to recommend confirmation of the function of this Board.

Confirmation of Designee for Small White House Conference

Mr. Richard Nelson, AMA Field Representative, gave information regarding this conference. There was general discussion. Governor Vandiver had appointed Secretary Mauldin to represent him at the conference and it was suggested that MAG pay Dr. Mauldin's expenses and charge to office travel. On motion duly made and seconded it was voted to send Dr. Mauldin to Washington for this conference with expenses underwritten by MAG as suggested.

Georgia Inter Agency Tuberculosis Committee Replacement

Mr. Krueger read the letter from this Committee requesting replacement for an outgoing member. On motion duly made and seconded it was voted to reappoint Walter S. Dunbar, Atlanta.

MAG Staff Employees Retirement Plan

Secretary Mauldin asked permission to work out some type of retirement plan. On motion (Hatcher-McDaniel) it was voted to instruct the Secretary to investigate pension plans and report back at some future date to Executive Committee.

"Doctor Image" Advertising Press Campaign

Secretary Mauldin and Mr. Krueger asked consideration of an advertising press campaign, and requested permission to go ahead with investigation of future plans with AMA and report to Executive Committee by September. On motion duly made and seconded it was voted to encourage this pursuit.

Telephone and Airline Credit Cards

Mr. Krueger asked for information regarding distribution of these cards yearly. On motion duly made and seconded it was voted to issue telephone credit cards to the President, Past President, Chairman of Council, Secretary, Executive Secretary and Assistant Executive Secretary; and to issue airline credit cards to Secretary, Executive Secretary, Assistant Executive Secretary, Bookkeeper and Executive Assistant. On motion (Hatcher-McDaniel) it was voted to use airline credit cards for MAG authorized trips only and to issue one to Mrs. Wooten.

Council Name Plates

Mr. Krueger asked Executive Committee's opinion regarding use of name plates at Council meetings. On motion duly made and seconded it was voted to table this item.

New Business

(a) President Simonton's acceptance speech in Congressional Record.

(b) Georgia Hospital Advisory Council—Dr. Mauldin suggested a Kerr-Mills Implementation representative orientation meeting prior to the June 28 meeting of the Georgia Hospital Advisory Council, for Doctors Conger, Pomeroy and Banks. On motion (Hatcher-Alexander) it was voted that the orientation meeting be approved.

(c) Workman's Compensation Program for MAG Employees: On motion duly made and seconded it was voted to refer this to MAG attorney for investigation.

(d) Nursing Home Accreditation Program: Secretary Mauldin asked for appointment of a liaison member. Deferred.

(e) Request for purchase of Fire Extinguishers: On motion duly made and seconded it was voted to purchase the number of extinguishers needed for MAG Headquarters Building and charge to office supplies.

(f) Date and Site of July Executive Committee meeting: July 22 at 2:00 P.M., and July 23 at 9:00 A.M., at President Simonton's farm.

This portion of the meeting was recessed at 11:13 P.M.

EXECUTIVE COMMITTEE RECONVENED

PRESIDENT SIMONTON called for a moment of silent prayer.

Alignment of Committee Reorganization Structure

President-Elect Goodwin gave background information regarding the committee reorganization structure.

The Executive Committee then designated the membership of the Boards and Sub-Committees under each Board as follows to be presented to Council for confirmation:

ASSOCIATION COMMITTEES

Executive Committee

Fred Simonton, Chickamauga, President (1962)
Thomas W. Goodwin, Augusta, President-Elect (1962)
Milford B. Hatcher, Macon, Immediate Past President (1962)
George H. Alexander, Forsyth, Chairman of Council (1962)
John T. Mauldin, Atlanta, Secretary (1963)
J. G. McDaniel, Atlanta, Chairman of Finance (1962)
Linton H. Bishop, Atlanta, First Vice President, Ex-officio

Finance Committee

J. G. McDaniel, Atlanta, Chairman
Virgil Williams, Griffin
Charles R. Andrews, Canton

Professional Conduct Committee

William P. Harbin, Jr., Rome, Chairman
H. D. Allen, Jr., Milledgeville
W. Bruce Schaefer, Toccoa
Luther H. Wolff, Columbus
Milford B. Hatcher, Macon
Charles S. Jones, Atlanta

Woman's Auxiliary Advisory Committee

Luther H. Wolff, Columbus, Chairman (1962)
Remer Y. Clark, Marietta (1962)
W. G. Elliott, Cuthbert (1963)
A. Worth Hobby, Atlanta (1962)
Virgil B. Williams, Griffin (1964)
Milford B. Hatcher, Macon, Ex-officio
Fred H. Simonton, Chickamauga, Ex-officio

ASSOCIATION BOARDS

BOARD OF MEDICAL EDUCATION

J. W. Chambers, LaGrange, Chairman (1964)
T. A. Sappington, Thomaston, Vice Chairman (1964)
George Dillinger, Thomasville (1963)
Walter Bloom, Marietta (1962)
W. D. Jarrat, Macon (1962)
W. H. M. Weaver, Macon (1963)

Sub-Committee on Medical School Course

T. A. Sappington, Thomaston, Chairman
F. N. Harrison, Augusta
Alton V. Hallum, Atlanta

Sub-Committee on Medical Education

Walter Bloom, Marietta, Chairman
James C. Metts, Savannah
J. Willis Hurst, Atlanta
Harry B. O'Rear, Augusta, Ex-officio
A. P. Richardson, Atlanta, Ex-officio

Sub-Committee on AMEF

W. D. Jarrat, Macon, Chairman
Corbett H. Thigpen, Augusta
C. B. Elliott, Cedartown
Edgar Boling, Atlanta
Mrs. Bruce Threatte, Columbus
Ralph W. Fowler, Marietta

BOARD OF HOSPITAL ACTIVITIES

Ralph N. Johnson, Rome, Chairman (1964)
Walter E. Brown, Savannah, Vice Chairman (1964)
Ben K. Looper, Canton (1963)
Rafe Banks, Gainesville (1963)
Jack C. Norris, Atlanta (1962)

Sub-Committee on Clarksville Labs.

Ben K. Looper, Canton, Chairman
Sam Talmadge, Athens
Hamil Murray, Gainesville
Lee Howard, Jr., Savannah

Sub-Committee on Blood Banks

Jack C. Norris, Atlanta, Chairman
Irving Greenberg, Atlanta
Walter Sheppard, Augusta

Sub-Committee on Hospital Relations

Rafe Banks, Gainesville, Chairman
W. L. Pomeroy, Waycross
Milford B. Hatcher, Macon
C. W. Mills, Jr., Atlanta
P. W. Warga, Athens

BOARD OF GOVERNMENT MEDICAL SERVICES

Luther H. Wolff, Columbus, Chairman (1964)
W. Bruce Schaefer, Toccoa, Vice Chairman (1964)
A. W. Simpson, Washington (1963)
Eugene Griffin, Atlanta (1962)
Edgar M. Dunstan, Atlanta (1962)
Robert L. Bennett, Warm Springs (1962)
R. W. Edenfield, Macon (1963)
Grady W. Black, Griffin (1963)

Sub-Committee on Maternal & Infant Welfare

Eugene Griffin, Atlanta, Chairman
Helen W. Bellhouse, Atlanta, Vice Chairman
Luella Klein, Atlanta
J. W. Smith, Manchester
William A. Laupus, Augusta

Sub-Committee on Public Health

R. W. Edenfield, Macon, Chairman
Alex G. Little, Valdosta
Lee H. Battle, Jr., Rome
Hugh J. Bickerstaff, Columbus
Virgil Williams, Griffin

Sub-Committee on Medical Civil Preparedness

Edgar M. Dunstan, Atlanta, Chairman
Harrison Reeves, Atlanta
Charles E. Dowman, Atlanta

Sub-Committee on School Child Health

Grady W. Black, Griffin, Chairman
J. C. Hughston, Columbus
William H. Bonner, Athens

Sub-Committee on Veterans Affairs

W. Bruce Schaefer, Toccoa, Chairman
Lee Howard, Jr., Savannah
F. P. Holder, Eastman

Sub-Committee on Rehabilitation & Crippled Children

Robert L. Bennett, Warm Springs, Chairman
Thomas P. Goodwyn, Atlanta
W. Upton Clary, Savannah
J. C. Hughston, Columbus
James W. Bennett, Augusta
Atwood M. Freeman, Jr., Albany

BOARD OF VOLUNTEER HEALTH AGENCIES

R. C. Pendergrass, Americus, Chairman (1964)
P. T. Scoggins, Commerce, Vice Chairman (1964)
Maurice Arnold, Hawkinsville (1963)
F. G. Elridge, Valdosta (1963)
Thomas L. Ross, Macon (1962)

Sub-Committee on Mental Health

Maurice Arnold, Hawkinsville, Chairman
Benjamin F. Moss, Jr., Augusta
Bernard C. Holland, Atlanta

Sub-Committee on Cancer

R. C. Pendergrass, Americus, Chairman
Hoke Wammock, Augusta
Ralph J. Davis, Rome
John T. Mauldin, Atlanta
H. H. McGee, Jr., Savannah

BOARD OF OCCUPATIONAL HEALTH

T. A. Peterson, Savannah, Chairman (1964)
C. L. Ridley, Jr., Macon, Vice Chairman (1964)
C. R. Andrews, Canton (1963)
Charles McArthur, Cordele (1962)
Joseph E. Griffith, Marietta (1963)

Sub-Committee on Industrial Health

C. L. Ridley, Macon, Chairman
T. A. Peterson, Savannah
Henry S. Jennings, Jr., Gainesville

Sub-Committee on Rural Health

Charles McArthur, Cordele, Chairman
Reid Gullatt, Cochran
Carl S. Pittman, Jr., Tifton

BOARD OF INTERPROFESSIONAL RELATIONS

J. G. McDaniel, Atlanta, Chairman (1964)
Henry Finch, Atlanta, Vice Chairman (1964)

Frank McKemie, Albany (1963)
William Coles, Atlanta (1962)
Samuel U. Braly, Dallas (1963)

BOARD OF PUBLIC SERVICE

Linton H. Bishop, Atlanta, Chairman (1964)
Floyd Sanders, Decatur, Vice Chairman (1964)
M. A. Hubert, Athens (1962)
August S. Yochem, Jr., Atlanta (1963)
Joseph B. Mercer, Brunswick (1963)

Sub-Committee on Weekly Health Column

August S. Yochem, Atlanta, Chairman
Alfred H. Randall, Jr., Marietta
J. Bothwell Traylor, Athens
Hamil Murray, Gainesville
J. Harry Rogers, Atlanta
C. J. Wyatt, Jr., Rome
Robert C. Garner, Atlanta
E. P. Inglis, Marietta
Ben H. Jenkins, Newnan

Sub-Committee on Public Service

Joseph B. Mercer, Brunswick, Chairman
William C. Coles, Atlanta
Thomas N. Lumsden, Clarkesville

BOARD OF LEGISLATION

J. Frank Walker, Atlanta, Chairman (1964)
John A. Bell, Jr., Dublin, Vice Chairman (1964)
Lester Harbin, Rome (1963)
W. J. Williams, Augusta (1963)
Howard Derrick, LaFayette (1962)

BOARD OF INSURANCE AND ECONOMICS

David R. Thomas, Jr., Augusta, Chairman (1964)
W. L. Pomeroy, Waycross, Vice Chairman (1964)
H. D. Pinson, Augusta (1963)
A. M. Phillips, Macon (1963)
Charles S. Jones, Atlanta (1962)

Sub-Committee on Relative Value Study

Harry D. Pinson, Augusta, Chairman
Robert E. Cato, Macon
Remer Y. Clark, Marietta
Joseph E. Griffith, Marietta
David R. Thomas, Augusta
E. C. Whatley, Reynolds
Henry Jennings, Gainesville

BOARD OF CONSTITUTION AND BYLAWS

W. G. Elliott, Cuthbert, Chairman (1964)
J. L. Mulherin, Augusta, Vice Chairman (1964)
Virgil Williams, Griffin (1963)
Lee H. Battle, Rome (1963)
Milford B. Hatcher, Macon (1962)

BOARD OF ANNUAL SESSION

Peter Hydrick, College Park, Chairman (1964)
Braswell Collins, Macon, Vice Chairman (1963)
Thomas W. Goodwin, Augusta (1964)
Henry H. Tift, Macon (1962)
M. Freeman Simmons, Decatur (1963)
Oscar Lott, Savannah (1962)

BOARD OF SPECIAL ACTIVITIES

John S. Atwater, Atlanta, Chairman (1964)
Frank L. Wilson, Jr., Leslie, Vice Chairman (1964)
C. T. Cowart, LaGrange (1962)
Leo Smith, Waycross (1963)
Hoke Wammock, Augusta (1963)
Ralph W. Fowler, Marietta (1962)

Sub-Committee on Health Care of Aging

John S. Atwater, Atlanta, Chairman
John T. Mauldin, Atlanta
John L. Elliott, Savannah

On motion duly made and seconded Executive Committee voted to clarify that medical education will be under the Board

of Medical Education and that paramedical education will be under the Board of Hospital Activities.

There being no further business the meeting was adjourned at 1:20 P.M.

MAG COUNCIL MEETING

THE MEETING of the Council of the Medical Association of Georgia was called to order by Chairman George H. Alexander at 2:20 P.M., June 10, 1961, at the MAG Headquarters Building, Atlanta, Georgia.

The invocation was given by Chairman Alexander.

The Chairman then welcomed the new members of Council.

Council members present were: Fred H. Simonton, Chickamauga, President; Thomas W. Goodwin, Augusta, President-Elect; Milford B. Hatcher, Macon, Immediate Past President; George H. Alexander, Forsyth, Chairman of Council and Bibb County Medical Society Councilor; Linton H. Bishop, Atlanta; First Vice President; Lee H. Battle, Rome, Second Vice President; John T. Mauldin, Atlanta, Secretary; C. Raymond Arp, Atlanta, Treasurer; J. Frank Walker, Atlanta, Speaker of the House; Joseph B. Mercer, Brunswick, Vice Speaker of the House; Charles E. Bohler, Brooklet, First District; William Simmons, Sylvania, First District Vice Councilor; W. Frank McKemie, Albany, Second District Vice Councilor; Frank Wilson, Leslie, Third District; Virgil Williams, Griffin, Fourth District; C. T. Cowart, LaGrange, Fourth District Vice Councilor; Floyd Sanders, Decatur, Fifth District; Lawrence Matthews, Decatur, Fifth District Vice Councilor; William Rawlings, Sandersville, Sixth District; Ralph W. Fowler, Marietta, Seventh District; C. R. Andrews, Canton, Ninth District; Addison Simpson, Jr., Washington, Tenth District; M. A. Hubert, Athens, Tenth District Vice Councilor; Walter Brown, Savannah, Georgia Medical Society; T. A. Peterson, Savannah, Georgia Medical Society Vice Councilor; H. D. Pinson, Augusta, Richmond County Medical Society; W. P. Jordan, Columbus, Muscogee County Medical Society; J. G. McDaniel, Atlanta, Fulton County Medical Society; Charles S. Jones, Atlanta, Fulton County Medical Society Vice Councilor; AMA Delegates: Eustace A. Allen, Atlanta; and Henry H. Tift, Macon. Also present were Mr. Frank Shackelford and Mr. John Moore, MAG Attorneys; Mr. Richard Nelson, AMA Field Representative; Hoke Wammock, Augusta, Chairman of MAG Cancer Committee; Mr. Milton D. Krueger, Executive Secretary; Mr. James M. Moffett, Assistant Executive Secretary; and Mrs. Catherine Wooten, Executive Assistant.

The minutes of the Council meeting of May 6 and 10, 1961 were read by Mr. Krueger. On motion duly made and seconded these minutes were approved as read.

AMA Request for 1961 General Practitioner of the Year Nominations

Mr. Krueger read a letter from AMA requesting nominations for GP of the year. There was general discussion following this, and on motion (Simpson-Allen) it was voted not to participate in the nominations.

C. W. Long Memorial Museum and Public Service Correspondence

J. G. McDaniel read a letter from Lester Rumble regarding the closing of the C. W. Long Memorial Museum; a letter from John P. Heard was also read regarding his resignation as Chairman of the Public Service Committee. Both letters were received for information.

Macon Meeting Finance Report

Past President Hatcher gave Council a report on the Macon meeting, April 23, 1961. There is a deficit of \$654.79 over the amount of \$1,000.00 allotted for the meeting. On motion (Hatcher-Simonton) it was voted to take \$654.79 out of the Contingent Fund to make up this deficit.

Report of Treasurer

C. Raymond Arp, Treasurer, gave the report, and it was approved and received for information.

Legislative Committee Budget

J. Frank Walker stated that an additional \$800.00 would be needed for the remainder of this year and requested an additional appropriation. On motion (Goodwin-Simpson) it was voted that the deficit in the committee budget be underwritten and that the money requested be taken out of the Contingent Fund.

Annual Session Finance Report

Annual Session Chairman Henry Tift gave this report to Council. On motion duly made and seconded it was voted to thank the Annual Session Committee for the good job done at the 1961 Annual Session.

Gulf Life Letter Re: Taxes

Mr. John Moore, MAG Attorney, stated that no ad valorem taxes had been paid because of the fact that MAG's tax exemption status was being held in abeyance. Gulf Life Insurance Company's letter had been answered to this effect and no further word from them had been received.

MAG Hospitality Room for AMA Meeting New York, June 26-30

AMA Delegate Tift asked permission of Council to appropriate another \$500.00 for the use of a Hospitality Room, which would be especially useful this year because Eustace A. Allen is running for the position of Vice President of AMA. On motion (Mauldin-Simonton) it was voted to take \$500.00 out of the Contingent Fund and set it aside for use in the Hospitality Room at the AMA meeting.

Health Insurance Institute Appointments

Mr. Moffett gave Council information regarding the Health Insurance Institute and asked permission to designate three people from the Insurance and Economics Committee as representatives of MAG. The three members named were W. P. Rhyne, Albany; John L. Elliott, Savannah; and Charles S. Jones, Atlanta. On motion duly made and seconded permission was given Mr. Moffett to proceed as stated above.

Appointments to Workman's Compensation Medical Board

Secretary Mauldin stated that the Executive Committee had suggested the following for appointment to this board: A. P. Jones, Griffin; Floyd Sanders, Decatur; Warren B. Matthews, Marietta; G. Lester Forbes, Atlanta; Jack C. Norris, Atlanta; Hugh Hailey, Atlanta; David L. Hearin, Atlanta; Duncan Shepard, Atlanta; Richard L. Smoot, Decatur; Albert A. Rayle, Atlanta; and W. C. Coles, Atlanta. On motion duly made and seconded it was voted to confirm the recommendations of Executive Committee of the above appointments to the Workman's Compensation Medical Board.

Report of MAG Annual Washington Congressional Luncheon

AMA Delegate Eustace A. Allen, T. A. Peterson, J. Frank Walker and Mr. Moffett reported on this trip.

Proposed HR 4222 Campaign

Mr. Moffett read an outline of the proposed campaign program. Mr. Krueger then read a draft of testimony which could be presented before the House Ways and Means Committee by whomever the Association designates. On motion duly made and seconded it was voted to approve the entire program as outlined.

Rep. Carl Vinson Letter

Past President Hatcher read a letter from Rep. Vinson. This was received for information.

University of Michigan 14th Annual Conference on Aging

Mr. Krueger asked for Council's decision as to whether or not an MAG representative should attend this conference. On motion (Walker-Hatcher) it was voted to leave the decision to attend to John S. Atwater, Chairman, MAG Health Care of the Aging Committee.

AMA Resolutions

AMA Delegate Henry Tift discussed the following:

(a) Orthopedic-Podiatry Resolution: On motion (McKemie-McDaniel) it was voted to instruct our delegates to vote to refer this matter to the proper AMA committee for further study.

(b) AMA Support Resolution: The MAG House of Delegates had previously approved the endorsement of this Resolution.

Headquarters Office Report

Mr. Krueger reported on:

- (a) Public Relations Advisory Committee meeting in Chicago.
- (b) AMA Annual Session, June 25-30, 1961.
- (c) Political picture.

New Business

Chairman Alexander asked for new business items:

(a) Date and Site of next Council meeting: Referred to Executive Committee for decision.

This portion of the Council meeting was recessed at 5:15 P.M. Council was reconvened at 9:00 A.M., June 11, 1961 by Chairman Alexander.

Constitution and Bylaws Clarification

Mr. Frank Shackelford, MAG Attorney stated there was a ";" in the Chapter IV, Section 3. Confirmation of Executive Committee Appointments, which was in error but it does not, in his opinion, change the intent that Council confirm Executive Committee Board and Committee appointments.

Board and Committee Appointments

President Simonton explained to Council the lists of the Boards and Sub-Committees distributed to each member. After general discussion, on motion (McDaniel-Bishop) it was voted to accept the appointments in their entirety as amended. President-Elect Goodwin recommended that a meeting of each Board be held within sixty (60) days so that a report from each Board could be made to Council by the September meeting. On motion (Simonton-Mauldin) it was voted to approve this recommendation. It was recommended that the current budgets should apply for the previous committees until the budget is set up next year. On motion duly made and seconded it was voted to refer this to the Finance Committee for study and necessary action.

1961 House of Delegates Actions

The actions of the House of Delegates were discussed by Secretary Mauldin and Council took action on each of the recommendations. On motion duly made and seconded it was voted to send a copy of these actions to the Speaker of the House and that a report be made before the House of Delegates at the Annual Session of the previous year's actions, or incorporate them in the Speaker's Annual Report.

Attendance at House of Delegates Meetings

Due to poor representation of some county medical societies at the House of Delegates meetings, on motion duly made and seconded, it was voted to inform the Secretary of each county society, sixty days prior to the Annual Session of the necessity of being represented and the mechanics therein.

American Cancer Society Uterine Cancer Program

Hoke Wammock, Chairman, MAG Cancer Committee, brought information to Council regarding:

(a) Uterine cancer program sponsored by the American Cancer Society and the Georgia Cancer Society. On motion duly made and seconded this program was approved.

(b) A program for carcinoma of colon and rectum detection is being considered. Received for information.

(c) A teen-age cancer program to be continued. Approved.

(d) A Cancer Cavalcade program by Richmond County. Accepted for information.

On motion duly made and seconded it was voted to commend Dr. Wammock for his report.

Unfinished Business

(a) State Medical Journal Advertising Bureau Stockholder: Executive Committee recommended to Council that the SMJAB stockholder status be given favorable consideration. On motion duly made and seconded it was voted to adopt the resolution stated below and to purchase the stock from the Contingent Fund.

Resolution of

MEDICAL ASSOCIATION OF GEORGIA

The Chairman stated that an opportunity had been afforded the Corporation of purchasing twenty (20) Common Shares of the STATE MEDICAL JOURNAL ADVERTISING BUREAU, INC., an Illinois corporation, from the IOWA STATE MEDICAL SOCIETY. The terms under which such purchase would be made were stated to be a price of \$10 for each Common Share, or a total price of \$200 for the total Common Shares to be purchased. In addition, the Corporation would agree to be bound by the provisions of Article Five of the Articles of Incorporation of the State Medical Journal Advertising Bureau, Inc. which gave such Corporation the right and privilege of

purchasing all Shares owned or held by any Shareholders upon the occurrence of certain events.

Thereupon on motion duly made, seconded and carried, the following resolution was unanimously adopted:

RESOLVED, that the proposed purchase of twenty (20) Common Shares of State Medical Journal Advertising Bureau, Inc., an Illinois corporation, for a consideration of \$200 be and hereby is in all respects approved and that the Corporation does hereby agree to be bound by the provisions of Article Five, Paragraph 2 of the Articles of Incorporation of State Medical Journal Advertising Bureau, Inc., the form, terms and provisions of such Article Five having been presented to this meeting."

New Business

(a) Georgia Hospital Association letter: On motion duly made and seconded it was voted to send copies of MAG letter

of June 7, 1961 to GHA, GHA reply to MAG, and AHA stand on opposition to the King Bill, to MAG Council members.

(b) Indigent Physicians Pensions: It was recommended by Dr. McDaniel that this be referred to the Board of Insurance and Economics because the problem of small county medical societies matching pension payments to retired indigent physicians would work a hardship. On motion duly made and seconded it was voted to follow Dr. McDaniel's suggestion and to request that the Board report back to Council on its recommendations.

(c) Site of 1963 MAG Annual Session: On motion duly made and seconded it was voted to hold the 1963 meeting at Jekyll Island, and to notify Bibb County Medical Society to this effect, as they had also extended an invitation to hold the meeting in Macon in 1963.

(d) Hospital Boards Law: On motion duly made and seconded it was voted to refer this matter to the Board of Governmental Medical Services and the Board of Legislation.

(e) AMA Field Representative: Chairman Alexander recognized Mr. Nelson, who thanked MAG in behalf of the AMA for the work which this Association is doing.

There being no further business the meeting was adjourned at 11:50 A.M.

WHAT THE CONGRESS THINKS ABOUT MEDICAL AID TO THE AGED

MEDICAL WORLD NEWS recently conducted a poll to determine the position of Senators and Congressmen regarding medical aid for the aged financed under the Social Security program.

The results of the poll indicate considerable variance between the attitude of the Senate and that of the House of Representatives with the House easily being the most conservative of the two.

The results of the WORLD MEDICAL NEWS poll are:

IN THE SENATE

- 36% in favor of Federal medical aid for all aged.
- 18% in favor of Federal medical aid for the indigent only.
- 2% opposed any Federal medical aid program.
- 5% reached no decision as yet.
- 39% did not give position.

IN THE HOUSE OF REPRESENTATIVES

- 18% in favor of Federal medical aid for all aged.
- 31% in favor of Federal medical aid for the indigent only.

- 4% opposed to any Federal medical aid program.
- 6% reached no decision as yet.
- 41% did not give position.

SOCIAL SECURITY FINANCING OF MEDICAL AID PROGRAM IN THE SENATE

- 31% in favor of financing program through Social Security.
- 25% opposed to financing program through Social Security.
- 7% reached no decision as yet.
- 37% did not give position.

IN THE HOUSE OF REPRESENTATIVES

- 16% in favor of financing program through Social Security.
- 33% opposed to financing program through Social Security.
- 11% reached no decision as yet.
- 40% did not give position.

1961 CALENDAR OF MEETINGS

State

- Sept. 8-9—Thirteenth Annual Meeting, Georgia Heart Association, Jekyll Island.
- Sept. 14-16—Georgia Chapter, American College of Surgeons, The Cloister, Sea Island.
- Oct. 6-7—48th Annual Meeting of the Georgia Tuberculosis Association, Georgia Thoracic Society Annual Meeting, Atlanta Cabana Motor Hotel, Atlanta.
- Oct. 12-14—Georgia Academy of General Practice, Annual Session, Jekyll Island.
- May 6-9—Annual Session, Medical Association of Georgia.**

Regional

- Sept. 6-8—Southern T.B. Conference, Hot Springs, Arkansas.
- Sept. 15-17—South Carolina State Orthopaedic Meeting, William Hilton Inn, Hilton Head Island, South Carolina.
- Sept. 19-21—Kentucky State Medical Association, Brown Hotel, Louisville, Kentucky.
- Sept. 25-26—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tennessee.
- Oct. 21—Southeastern Allergy Association, Thomas Jefferson Inn, Charlottesville, Va.
- Nov. 6-9—Southern Medical Association, Municipal Auditorium, Dallas, Texas.
- Nov. 16-18—Southern Thoracic Surgical Association, Hotel Peabody, Memphis, Tennessee.
- Dec. 5-7—Southern Surgical Association, Hot Springs, Virginia.
- Mar. 2-5—Southeastern Surgical Congress, Louisville, Ky.
- Mar. 26-28—American College of Surgeons, Sectional Meeting, Hotel Peabody, Memphis, Tenn.
- April 8-11—Tennessee State Medical Association, Peabody Hotel, Memphis, Tenn.
- April 26-28—Alabama, Medical Association of the State of, Tutwiler Hotel, Birmingham, Ala.
- May 12-15—Texas Medical Association, Austin, Tex.

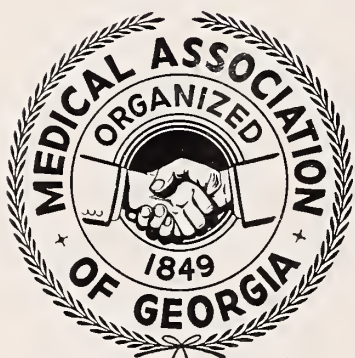
National

- Sept. 8-Nov. 10—New York University Postgraduate Medical School, Occupational Medicine, New York University Medical Center, New York, New York.
- Sept. 23-30—University of Illinois College of Medicine, Annual Otolaryngologic Assembly, Chicago, Ill.
- Sept. 25-28—American Hospital Association, Atlantic City, New Jersey.
- Sept. 25-29—American College of Chest Physicians, Postgraduate Course, Warwick Hotel, Philadelphia, Pennsylvania.
- Sept. 26-29—American Roentgen Ray Society, Deauville Hotel, Miami Beach, Florida.
- Sept. 28-30—American Association for the Surgery of Trauma, Drake Hotel, Chicago, Illinois.
- Sept. 30 - Oct. 3—College of American Pathologists, Seattle, Washington.

- Sept. 30-Oct. 8—American Society of Clinical Pathologists, Olympic Hotel, Seattle, Washington.
- Oct. 1-7—College of American Pathologists, Olympic Hotel, Seattle, Washington.
- Oct. 2-5—American Academy of Pediatrics, Palmer House, Chicago, Illinois.
- Oct. 2-6—American College of Surgeons, Conrad Hilton Hotel, Chicago, Illinois.
- Oct. 3-4—Congress on Occupational Health, Brown Palace Hotel, Denver, Colo.
- Oct. 8-13—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Illinois.
- Oct. 12-13—Congress of Neurological Surgeons, Summit Hotel, New York City.
- Oct. 15-20—Fourth International Congress of Allergology, the Hotel Commodore, New York, New York.
- Oct. 20-24—34th Annual Meeting, American Heart Association, Miami Beach, Florida.
- Oct. 22-25—American College of Gastroenterology, Hotel Cleveland, Cleveland, Ohio.
- Oct. 22-27—American Society of Anesthesiologists, Inc., Statler Hilton, Los Angeles, California.
- Oct. 23-24—American Cancer Society, Biltmore Hotel, New York City.
- Oct. 23-27—American College of Chest Physicians, Postgraduate Course, Sheraton-Chicago Hotel, Chicago, Illinois.
- Oct. 25-29—American Society of Clinical Hypnosis, St. Louis, Missouri.
- Nov. 2-12—Second Postgraduate Medical Seminar Cruise through the Caribbean. (College of Medicine, University of Florida)
- Nov. 4-5—American Medical Association Conference on Disaster Medical Care, Chicago.
- Nov. 9-11—American Academy for Cerebral Palsy, Chase & Park Plaza Hotels, St. Louis.
- Nov. 13-17—American College of Chest Physicians, Postgraduate Course, Park Sheraton Hotel, New York, New York.
- Nov. 13-17—American Association of Public Health Physicians, Detroit.
- Nov. 16-18—American Psychiatric Association, Hotel Schroeder, Milwaukee, Wis.
- Nov. 25-27—American College of Chest Physicians, Brown-Palace Hotel, Denver, Colorado.
- Nov. 25-Dec. 1—Radiological Society of North America, Inc., Palmer House, Chicago.
- Nov. 27-29—American Society of Hematology, Ambassador Hotel, Los Angeles, California.
- Nov. 27-30—American Medical Association, Clinical Meeting, Denver, Colorado.**
- Dec. 2-7—American Academy of Dermatology and Syphilology, Palmer House, Chicago, Illinois.
- Dec. 4-8—American College of Chest Physicians, Postgraduate Course, Statler-Hilton Hotel, Los Angeles, California.
- Feb. 5-7—American Academy of Allergy, Denver-Hilton Hotel, Denver, Colorado.
- Feb. 7-10—American College of Radiology, Roosevelt Hotel, New York, New York.
- April 2-5—American College of Obstetricians and Gynecologists, Palmer House, Chicago, Illinois.

1962 Annual Session

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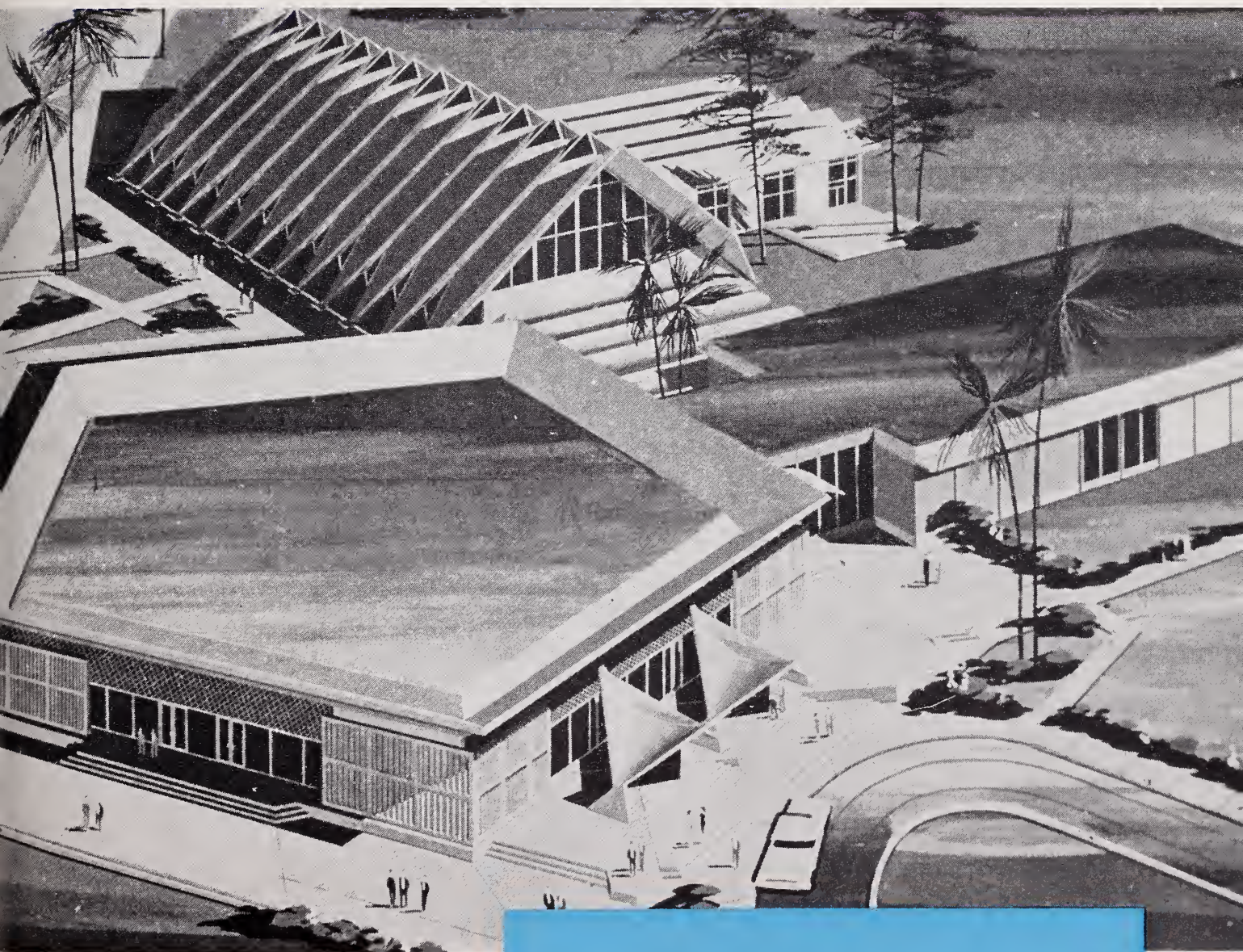
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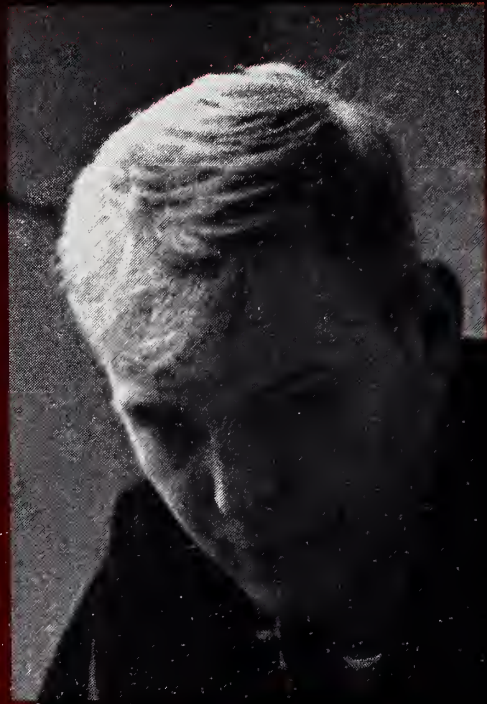
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**Scene of the Georgia
General Practitioner's
Thirteenth Annual Session**

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THE A.M.A. IN 1961

Leonard W. Larson, *Bismarck, N. D.*

Without the united acceptance by state and county medical societies the AMA cannot function effectively.

TODAY I WANT TO SPEND A FEW MINUTES examining the immediate future of American medicine. This may sound like a crystal ball seance, but I assure you that my powers of foretelling are extremely limited. Besides, I am not licensed to practice the spiritualist arts in Georgia.

Of course, we could spend hours conjecturing about the distant, hazy future of medicine and all its potentials. We could debate and discourse on cures for cancer and heart disease . . . victory over the common virus . . . and the extension of man's lifespan past 100 years.

But encouraging as these speculations may be, they are of little use for overcoming the immediate problems of 1961. Medicine has a great many headaches of its own to get rid of before we can move on freely and without confusion.

Therefore, my tea leaf reading will be confined to the immediate future . . . and I will discuss the activities and plans of the American Medical Association in 1961.

During the past year, several new programs and projects have been started by our association, many

of which are still underway. And even more important developments are planned for the immediate future.

Let me give you a quick rundown.

Our activities during the last year and during the coming months can be divided roughly into two groups: scientific-medical-health and political-socio-economic.

It is no secret that during 1960 and so far in 1961, the bulk of publicity about A.M.A. has centered on our legislative activities. I suspect this also will be true for the rest of the year.

I want to make it quite clear that while our political and legislative activities are the most publicized, *by no means* does this indicate a lack of activity in the scientific and medical fields. On the contrary, our scientific programs are of greatest concern to every physician and scientist.

A little later I will go into some detail about some vital scientific projects we are engaged in. Right now, however, let's look at what has been keeping us busy on the legislative front.

As you well know, the medical profession has equipped itself with a double-edged sword, one side of which is used to battle against the social security method of financing health care for the aged. The other side of our sword must be used to cleave through the enemy's obfuscations and win wide acceptance for the Kerr-Mills law—a program which the medical profession wholeheartedly supports, and

Presented at the 107th Annual Session of the Medical Association of Georgia, May 7, 1961, Atlanta, Georgia.

one which is designed to provide care for these aged patients who really need it.

We know that, if given an honest chance to demonstrate its many fine qualities, the Kerr-Mills law will do the job. We know, too, that if the social security scheme—personified in the King bill—goes through, our needy aged will be denied necessary care, and that the federal government will successfully entangle medical science in a maze of red tape and bureaucracy.

You know the task confronting us in medicine's most decisive year. No longer are we fighting undesirable legislation. Rather we now have an excellent weapon in the Kerr-Mills law with which to demonstrate the effectiveness of our approach to health care for the aged. It is up to us to see that this splendid law is given its proper chance to work.

In our efforts to encourage passage of the Kerr-Mills bill by Congress, as well as our efforts to defeat the Forand bill—the predecessor of the King bill—we utilized the fullest resources of our association. Our Washington staff . . . our Field Service representatives . . . our Communications division and our Legal and Socio-Economic division—all contributed to the fight *against* government medicine and *for* the Kerr-Mills Law.

But our activity has by no means ceased! We shall never cease to fight vigorously for what we believe is right. Here is what some of our divisions will be doing in the coming months:

Our Field Service division will continue to make the A.M.A. programs better known and understood by all physicians through the state and local medical societies. The purpose of this better understanding is to ultimately improve health and medical care.

The Field Service Division also will work to achieve better liaison with all kinds of groups in the allied field. And our field representatives are promoting a true scientific leadership by the A.M.A., which will come to pass only if every American physician understands, supports and contributes his knowledge to the A.M.A.

Legal and Socio-Economic Efforts

Our Legal and Socio-Economic Division has intensified efforts on all fronts. For example, we have called a National Conference on Quackery to be held in Washington this fall to gather together all the interested organizations and federal agencies concerned with fighting medical quackery.

Such groups as the Food and Drug Administration, the Better Business Bureau and the Chamber of Commerce will meet with the A.M.A. representatives to discuss all forms of medical quackery—mechanical, nutritional and the like.

This national conference is part of our overall campaign started last year to help the American public spend its health dollars more wisely. We believe that millions of dollars each year are wasted on useless food supplements, dietary reducing aids, quack remedies and unnecessary self-medication.

Our Council on Medical Service has inaugurated an important perinatal mortality and morbidity study, to determine the causes of death immediately before, during and after birth. Medical science has effectively reduced maternal mortality to an historical low, but there is still some work to be done in the infant mortality area.

Since announcing this study, we have received overwhelming acceptance and cooperation from hospitals and their staffs throughout the nation. Right now, the study is in pilot form, but we hope to expand it into a broad program soon.

Another important development has been the formation of an Economics Advisory Committee, composed of ten leading economists, sociologists and educators. This group has been of great value to the association, and we look forward to even greater use of its potentials.

During March and April medico-legal conferences were held in San Francisco, Louisville and New York, to help bring about better cooperation and understanding between physicians and the legal profession.

Turning to the scientific activities of our association, several new developments for 1961 are planned. Our Council on Scientific Assembly has had a tremendous response to its plan to hold a research forum with allied medical and health groups during the annual meeting in New York next month.

In October the first National Congress on Prepaid Health Insurance will be held in Chicago.

Several important publications have been prepared by our Council on Foods and Nutrition. Two which will be published shortly include a council report on the relationships of dietary fats to cardiovascular disease, and a statement on the carcinogenic agents in food additives. Just last week, a statement on the use and abuse of formula weight reducers was published in the JOURNAL.

The council also is working on a scientific study of dietary effects on the gastro-intestinal tract. The purpose of this is to install sense and logic into the use of diets such as bland diets, ulcer diets, etc., on the gastro-intestinal tract.

Next October a symposium on teenage nutrition will be held at Stanford University in California.

Our Department of Drugs has expanded and some of its projects include a new column in the journal of the A.M.A., "New Drugs and Developments in Therapeutics" . . . improved standards of nomen-

clature for the U. S. Pharmacopeia . . . and participation in a program providing full disclosures of drug ingredients to physicians.

Our Committee on Rehabilitation is working on a program to state and local society directories of rehabilitation services. Also scheduled for 1961 is a pilot survey of rehabilitation services within selected states, to evaluate their effectiveness as well as any defects.

In the very important realm of medical education, one of our major activities this year is implementing the program to insure that graduates of foreign medical schools who serve as interns and residents in American hospitals are properly qualified and trained.

In December the House of Delegates encouraged the development of special education programs for those interns and residents preparing to take the examination administered by the Educational Council for Foreign Medical Graduates—E.C.F.M.G.

Also, the Special Study Committee of the council will continue to implement the scholarships and loan programs, as well as recruitment and expansion of education facilities. This committee expects to present a full report on its activities to the House at the June meeting in New York.

Developments in Medical Education

Some of the other developments in medical education include a study of the possibilities of increasing the stipends for residents, taking into consideration their age, education and professional status . . . the formation of new committees to look at objectives of internship and residency programs, their content and quality, and how they can best be evaluated for accreditation . . . a study of the whole area of post graduate medical education, and the stimulation of better continuing education . . . and a program of participation in more meaningful liaison with the sciences and allied health services.

Our Division of Environmental Medicine has embarked on a great number of significant projects, many of which bear an immediate importance to the health of our nation. This division's activities encompasses virtually everyone, including the public at-large . . . athletes . . . missionaries and diplomats . . . members of the Armed Forces . . . urban workers . . . and farmers.

Our Environment Medicine Division plans during 1961 to place increased emphasis on community health, providing for the individual those health benefits which he cannot acquire for himself.

Our Department of Health Education has started expanding and strengthening the pamphlet programs. The first of the year inaugurated a new monthly publication, "Health Education Service for Schools and Colleges." This is designed to provide teachers

and school health authorities with current health news in concise form.

A new department, that of International Health, has been staffed and is rapidly progressing in its duties of coordinating all A.M.A. programs concerned with international health. We feel that our association is in the best position to assume leadership in this essential area. Our department will be working closely with such organizations as the World Medical Association, the World Health Organization and the International Cooperation Administration, part of the State Department.

During 1961, our Council on National Security will be placing increased emphasis on military affairs. The A.M.A. House of Delegates has recognized the need for medical leadership at the highest echelons of military affairs. We also are encouraging the training of medical corps officers for the broadest services on military staffs. This means that the doctor who joins, or is drafted into, the armed forces should be thoroughly acquainted with all aspects of military life, so that he may be that much more effective.

Our Committee on Aerospace Medicine is supporting a program for federal designation of medical examiners to award flying certificates for private pilots. The A.M.A. and the federal government would cooperate in selecting examiners.

One of the most exciting and challenging projects is intensified study and research into the medical aspects of human travel. It is obvious that medical science must play a most important role in putting a man into space and keeping him alive. Strong medical leadership is essential to speeding the dawn of the space age.

The Committee on the Medical Aspects of Automobile Injuries and Deaths will continue its activity during the coming year, stressing a program of medical examination as part of all driver licensing programs.

Our concern for the increasing slaughter on America's highways has led us to fight for better testing of drivers, as well as better design of automobiles. We believe that while driver negligence is the cause of many serious or fatal accidents, much of the bloodshed would be eliminated by including safety devices as standard equipment—not extras—on all automobiles. Seat belts—padded dashboards—pop-out windshields . . . less interior junk—all these are essential to cutting down traffic carnage.

One of our Rural Health programs of particular significance for rural physicians is a study of the medical and public health aspects of migratory laborers.

I could go on and on for hours telling you details of the many new and continuing projects of the American Medical Association. However, I think

I've given you enough of a hint to arouse your interest.

Quite honestly, most of these programs depend heavily on your support and cooperation. Without the united acceptance by state and county medical societies, the A.M.A. cannot possibly function

best to serve the American physician and the public to further the development of the art and science of medicine.

For your own good, for the good of your patients and for the good of the nation, I hope you will take a vigorous and active interest in the American Medical Association—your organization.

221 5th Street

A.M.A. DUES INCREASE

AN ANNUAL DUES increase of \$20, to be implemented over a period of two years, was approved by AMA's House of Delegates at the Annual Meeting in New York City.

Dues were established at \$25 in 1950 and have not been changed since.

Action calls for an increase of \$10 on Jan. 1, 1962, and \$10 additional on Jan. 1, 1963. When this increase becomes effective, the annual dues for active members will be \$35 a year in 1962 and \$45 in 1963.

REASONS FOR INCREASE: AMA's Board of Trustees informed the House of Delegates at the Annual Meeting in Miami Beach in June, 1960, that a dues increase would be necessary. At its meeting in Washington, D. C., in December, 1960, the House approved bringing the recommendation before the policy-making body at its 1961 meeting.

In recommending a dues increase to the House of Delegates, the Trustees said the programs of the American Medical Association are determined by the health needs of the nation and services required by physician members to keep them abreast of the latest developments in medicine.

SOURCES OF INCOME: AMA's current programs demand more money than its present income, the Board said.

Total income in 1960 was \$15,961,000—22.8 per cent of which was derived from membership dues. Other sources of income were: advertising, 51.1 per cent, outside subscriptions, 14.4 per cent; miscellaneous, 6.7 per cent; exhibits, three per cent, and investments, three per cent.

EXPANDED PROGRAMS: The House of Delegates disapproved of earmarking any portion of the increase in dues for any specific purpose. However, among the new and expanded AMA programs for which the additional income will be used are:

- A far-reaching new drug information program which will serve to add to the physician's store of knowledge for the benefit of the patient; participation with the American Pharmaceutical Assn. and the United States Pharmacopeia in the enlarged program of a drugs standards laboratory; a coopera-

tive program for selection of nonproprietary names for drugs, dovetailing the nomenclature interests of AMA's Council on Drugs and the U.S. Pharmacopeia.

- A complete study of internships and residencies in the United States to determine:

- (1) Specific purposes to be achieved by graduate medical education, including a consideration of the various careers necessary for medicine to provide the public with medical service of a quality limited only by the boundaries of medical knowledge.

- (2) Set forth the ideal design of educational programs to accomplish the purposes determined.

- (3) Outline plans to alter existing programs so that they may reach the ideal as quickly as possible.

- A study of immediate problems related to internship programs with recommended policies to achieve a better balance between the total of approved internships and the number of interns available to fill them, and to suggest other mechanisms by which the service needs of hospitals may be fulfilled in the absence of intern or resident staffs.

- Medical recruitment program to attract more talented medical students into medical careers, a student honors program, and financial assistance to medical students.

- A vigorous effort to combat mental illness, including a conference on mental health to be held in Chicago, Sept. 29-Oct. 1. The conference will bring together leaders in the field to review the present status of mental health and to outline a comprehensive program for AMA to embark upon.

- Health and safety education program for the public with increased emphasis on healthful living habits, physical fitness of young people, traffic safety, air and water pollution, preventive medicine, and the elimination of misleading advertising of health care products.

- International health program to work with world medical organizations to help bring better health to all people everywhere and to assist medical missionaries in carrying out their medical responsibilities around the world.

SOME MEDICOLEGAL CONTRIBUTIONS OF THE GENERAL PRACTITIONER

George E. Hall, J.D.,* *Chicago, Ill.*

*Six areas in which the generalist
can make valuable medicolegal contributions
are discussed.*

PROBABLY I SHOULDN'T TAKE TOO much pride in the title of my part in your program this morning, even though I was the one who suggested it. It sort of came off the top of my head about six months ago when I learned that I was going to be a participant in this General Practitioner's Session. As I started to get a few thoughts together, however, I realized how lucky my choice of a topic was. The more I thought about it, the more I became convinced that the General Practitioner is in some ways in a unique position to make special medicolegal contributions on behalf of the entire profession.

I have the feeling that if someone were to ask you whether or not you are an educator, you'd all say "NO"—and of course you aren't, in a technical sense. I do believe, however, that your greatest medicolegal contributions are in the broad field of education and I'd like to mention six areas in which this is particularly true.

ONE: One of your educational activities consists in acting as witnesses in judicial and quasi-judicial hearings. Your primary duty as a witness, of course, is to educate a judge and/or jury as to the medical facts of a particular situation. The types of hearings are numerous and the scope of testimony

necessarily varied. You are all, of course, familiar with the need for medical testimony in malpractice cases and in the usual personal injury case. You contribute your knowledge to other types of cases, too, though. In adoption cases, for example, you are asked to evaluate the present and future health of a baby and sometimes, also, to assess the physical condition of the adopting parents. In workmen's compensation hearings you must educate the hearing officer as to the extent of physical or mental impairment which an employee may have suffered as the result of an occupational accident. In many rural areas a General Practitioner is often asked by the coroner's office for assistance in determining time and cause of death in suspected homicide cases and by the police for information concerning the physical condition of the victim of a rape or other felonious assault. In Will contests and in commitment proceedings you may be asked to explain or evaluate conditions or conduct affecting an individual's mental state. This latter responsibility will be falling more and more on the General Practitioner as general hospitals establish psychiatric wards, as psychiatric hospitals admit General Practitioners to staff privileges and as voluntary, rather than judicial, commitments increase.

To the extent that the General Practitioner fulfills these educational obligations, he becomes a good witness and furnishes a necessary and important medicolegal contribution to the proper administration of justice.

TWO: Another area in which a General Practitioner finds himself assuming the role of an educator is as medical consultant to the legal profession

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* Director of the Department of Legal Medicine of the American Medical Association.

—more particularly as a consultant to attorneys who must present a medicolegal issue in court. No attorney who is handling a law suit in which the physical or mental condition of a party is in issue will want to, or should enter upon the trial of the case until he has learned all he can about the particular disability involved. He will gain some of his needed information from the medical reports which you, as attending physicians, will have prepared. He will gain some by studying medical books written especially for lawyers. He will gain the best quality of education, however, by consulting the attending physician who, in more cases than not, is a General Practitioner. Not only can you educate him concerning the medical facts involved. You can also assist him in preparing questions for examination and cross-examination so that the medical facts can be best presented to the judge and jury. In this function the General Practitioner is often more adequate than the specialist. For the benefit of any specialists in the audience I hasten to add that this is, of course, not always so. By and large, however, the General Practitioner is a better communicator of medical information in lay terms than is the specialist. He is more frequently called upon to explain things to the patient than is the specialist, who often makes his reports directly to the referring General Practitioner rather than to the patient. The General Practitioner will therefore have a better chance of “getting through” to the attorney in language the attorney will understand. This ability to avoid the use of technical terms in discussing problems with patient and attorney also makes the General Practitioner an excellent witness in the various legal proceedings I have previously mentioned. Converting technical medical terms into language which patient, attorney, judge and jury can understand is a most valuable medicolegal contribution which can be, and is, made by General Practitioners.

THREE: A third educational venture, so far as your medicolegal contributions are concerned, takes you into the field of civic affairs. Today, many legislative proposals, and many programs involving various aspects of the administration of justice, require a large amount of public education to guarantee their enactment and successful administration. For example:

A. Many localities are not yet taking advantage of scientific discoveries which are available to law enforcement officials in identifying and punishing drinking drivers. Often a local police department is aware of the advantages of using chemical tests to determine whether or not a driver involved in an automobile accident has been imbibing too freely.

Perhaps the department has been unable to convince the village fathers that the expense of the testing device is warranted—or perhaps it has been unable to gain the support of the local bar and citizenry. If so, here is where the General Practitioner can make his contribution. He can participate in panels and forums at local civic organizations and explain the effect of alcohol on driving ability, the relationship between alcohol ingested and alcohol in the breath, blood and urine, the validity of the content classifications set forth in the chemical test laws, the principles of the tests themselves, the general acceptability of these tests by the profession, etc.

B. When improvement is needed in the medicolegal investigative functions of a coroner's office, the General Practitioner is the person best qualified to take the stump to tell the public what the coroner's physician or medical examiner should be able to do, what kind of training he should have received, how he can assist the law enforcement officials in convicting guilty persons and in absolving innocent persons.

C. Who but the General Practitioner can best explain to the public the scientific aspects of programs to fluoridate public water supplies, the things to be careful about in the non-legal aspects of adoption proceedings, the great need for additional knowledge and treatment facilities in the mental illness field, the benefits of an adequate school health program? It is true that specialists have as great an obligation as the General Practitioner to support these worthwhile programs, and have as much knowledge concerning them. As indicated above, however, the General Practitioner is usually a little closer to the public pulse and a little more used to talking in language the public will understand.

FOUR: The General Practitioner also plays a significant role in the development of improved relationships between law and medicine. Sometimes specialists do not make the best impression outside of the profession because of a suspicion (happily unwarranted in most instances) that they have some special axe to grind or benefit to receive. This is not as apt to be true of General Practitioners. They have therefore been extremely helpful in many states and cities in negotiating interprofessional codes between doctors and lawyers. Perhaps you General Practitioners can undertake this contribution to medicolegal relations here in Georgia some time in the future.

FIVE: In our studies of malpractice statistics through the years, we at the AMA have become convinced that many instances of actual malpractice occur which never materialize into a claim or suit against the physician involved because of the solidarity of the physician-patient relationship. For this

reason we advise physicians that a full disclosure of negligent conduct is the physician's best course of action. Here is an actual example. Hospital X had adopted an operating policy of counting sponges in groups of eight. During an operation a sponge was accidentally, and without the knowledge of the nurse making the sponge count, sent to the laboratory along with some tissue which was to be examined by the pathologist. When the operation was completed and the sponge count made, there were six groups of eight sponges and the count was assumed to be correct. Later the one sponge in the laboratory came to light. Where were the other seven? That's right. They were in the patient. The surgeon immediately made a full disclosure to the patient and her family and indicated that a second operation would have to be made for removal of the sponges. Consent was given; a successful operation, for which no charge was made, was performed; and the patient was dismissed from the hospital. The family was so grateful for the surgeon's complete honesty and frankness, plus the fact that there were no bad after effects, that it had no thought of suing for damages.

No one has ever, so far as I know, attempted to estimate just how many malpractice suits are prevented each year simply because the attending physician, on the basis of an excellent rapport, has been able to convince the patient and his family that all that could have been done was done, and that what happened was just one of those unavoidable things. Actually I don't quite know how an accurate count of such instances could be made anyway. I won't try to kid you. I don't know for sure that the physician involved in the example I just gave you was a General Practitioner. I do think, however, that by and large the attending General Practitioner has a better chance of establishing the type of physician-patient relationship that will breed the necessary trust and faith. Certainly it will be agreed that reducing malpractice claims and suits is a most worthwhile medicolegal contribution.

SIX: The last medicolegal contribution of the General Practitioner that I will mention this morning is one which you would just as soon not have made. A lawsuit has been rather aptly described as a sociological autopsy. As in the case of the medicolegal autopsy, in a lawsuit, an attempt is made to determine and interpret the facts concerning a previous issue or situation. In order for there to be a need for this sociological autopsy, there must be what we term a plaintiff and a defendant. Conclusions reached on the basis of the facts found at this autopsy are termed "the law of the case" and are used as guides or precedents for analyzing future sociological autopsies involving the same or similar fact situations. It is by having been cast in the role of defendant so

many times during the course of the last century that the General Practitioner has, perforce, played an important part in the development of the law of malpractice. When is the physician-patient relationship created? How is it created? How and when is it, or can it be, terminated? What is the standard of care owed to a patient? How is compliance or non-compliance with this standard determined? Does the law countenance a difference of opinion among medical practitioners? What rights does an emergency give to a physician? Is there a physician-patient privilege? Is the physician bound by a right of privacy in the patient? Is a physician a guarantor of results? The answers to these questions represent but a few of the general principles of the law of malpractice which have had to be determined by means of a sociological autopsy. I'm not saying that General Practitioners were the defendants in all of these suits. Since today's high percentage of specialists is of comparatively recent origin, however, it is certainly fair to assume that many of the initial decisions in these areas were against General Practitioners, however. The rest of the profession owes you a debt of gratitude, therefore, for this extremely important, albeit unwilling, contribution to the field of legal medicine. Although new decisions and interpretations appear each year, the basic opinions handed down thirty, or more, years ago are pretty much the physician's and attorney's guide today.

CONCLUSIONS: Now some of you may be saying that I have stretched a point or two in favor of the General Practitioner since I am participating in a General Practitioner Day Program. I plead guilty to this—but only to a very small degree. I sincerely believe that the General Practitioner has played, and is playing, an increasingly important role in the civic, and medical and medicolegal affairs of his community.

There are three classes of residents in any community: those who live off it, those who live in it, and those who live for it. The first class are parasites, reaping where they do not sow. The beggar description. The second class lives in the community but has little or nothing to do with its activities. If enough of the population are in this group, there is community hari-kari. The third class of residents of a community—those who live for it,—recognize their political, social, and economic duties as citizens by adopting an attitude of true civic brotherhood. Such men meet on common ground, regardless of professional status, social status, physical possessions, religion, or politics. Can it not be said with pride that General Practitioners belong to the third group and respect this common ground? Truly aren't they the doctors of the community who live for their community?

535 N. Dearborn Street

Human error is the major factor in serious reactions.

TRANSFUSION REACTIONS

James J. Griffitts, M.D., *Miami, Fla.*

A NUMBER OF YOU MAY REMEMBER transfusion of blood as it was done in the 1930's. My recollection, colored by the passing of time, is that if the transfusion did not cause the patient to shake, shiver and later sweat, the therapeutic value of the blood was questioned. These chill and fever reactions were expected—now they are relatively rare, perhaps in only one of 40 transfused patients. This reduction is due to the use of professionally prepared disposable donor and recipient sets and donor blood containers.

Chills and fever, classed as pyrogenic, remain the most common untoward reactions incident to blood transfusion. Characteristically, the reaction begins with a chill or chilliness, usually after 140 cc of blood has been administered or within an hour after the transfusion. This is followed within a few minutes by a temperature rise, usually to 103° to 104° F. The amplitude of the increase in temperature is usually greatest if the patient is afebrile at the beginning of the transfusion. In our studies approximately half of transfused patients had temperatures at the start of 99.4° F. or higher.

Chills are not commonly reported in children, and are usually absent as an early sign of febrile response in persons under anesthesia who receive blood. This deprives the anesthesiologist of a valuable warning. In anesthetized patients, the recognition of a pyrogenic reaction is detected by noting temperature rise, increases or decreases in blood pressure and occasionally an increased tendency to bleed from operative wounds.

The chill and fever reaction is limited. Usually the temperature falls to pre-transfusion levels within two hours, and most often no sequelae complicate

the transfusion. Reactions beginning four hours after transfusion are not considered to be due to the blood. There have been one or two instances which are suggestive of a delayed reaction, similar to serum sickness, coming on in a week or more following transfusion, but evidence for this association with the blood transfusion is not stout.

At present, we do not know how to eliminate all chill and fever reactions. It is known that patients who require repeated transfusions often become subject to febrile reaction to each transfusion. In our studies of reactions connected with 121,000 transfusions, 11 per cent of all chill and fever reactions occurred in only 70 of more than 50,000 patients. We found no immunological basis as a cause, though this may some day be proved to be, when technics for study are advanced. It is known that some pyrogenic reactions may be avoided by removing most of the white cells from the blood. This is a procedure for the skilled laboratories to perform.

The onset of a chill or sharp temperature rise during transfusion signals to discontinue the pro-dangerous hemolytic reaction due to immunological incompatibility. The unused blood should be returned to the laboratory together with a freshly drawn sample of blood from the patient. The next urine voided should be sent to the laboratory for study.

Hemolysis of donor red cells may be due to over-aged blood, extravasations, contaminated blood or to recipient's antibody. Blood which is improperly stored or overaged should not be given. Infusion of blood into soft tissues, as may happen when the procedure is not under sufficient supervision, can be avoided. Care in the selection of donors, donor arm preparation, and good bleeding technics into sterile

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containers, will practically eliminate gross contamination.

Immunologic incompatibility poses a great risk to recipients of blood. Our present state of knowledge about blood cell factors makes it appear that the chances of giving, at random, a recipient blood identical in all factors to the patient's own, is about one in 40,000. Thus, we as transfuse (and as women continue to bear children) there are induced antibodies to blood factors unknown five, 10, or 15 years ago. The greatest hazards remain in the originally described O, A, B, AB groups—since it is natural and expected for most persons to have anti-A or anti-B. After this comes the Rho factor—then hr', rh', rh', Kell, Duffy, Lewis, and many other specific antibodies. We routinely test and select blood group and Rho compatible blood, and try to avoid sensitization of persons who are Rho negative. But, it is not possible to avoid sensitizing persons to the rare antigens and still issue blood for its lifesaving property.

At best, with due care and much understanding, we can avoid almost all incompatible transfusion reactions by detecting existing patient's antibodies by crossmatching. When certain incompatibilities are found, much work and time is consumed in selecting compatible blood for the patient, a fact we hope you all appreciate.

Incompatible blood usually causes a chill, pains in the legs and back, headaches, nausea and vomiting. Almost always there is hemoglobinemia and hemoglobinuria. The excessive destruction of donor cells gives rise to jaundice and when the reaction is severe, shock is present. It becomes apparent that the ability to excrete urine is markedly reduced or almost absent. This is, together with grossly contaminated blood, the most life-threatening reaction to transfused blood. Survival depends upon the ability to nourish the patient, control fluid and electrolyte intake and *pray* for a return of kidney excretion which usually will take place in severe cases in 10-14 days, or never. Since the onset of the incompatible reaction is not distinguishable from the more common febrile reaction, one must discontinue blood transfusion at the first sign of reaction in the patient to avoid the increasing insult of incompatible blood. Usually such reactions occur earlier during the transfusion—within the first 50 to 100 cc. Many transfusionists carefully observe the first 50 to 100 cc given very slowly, and then speed up the remainder of the apparently compatible transfusion.

I have thus far spoken of reactions which, at least in part, are under the control of the laboratory collecting, storing and crossmatching blood. On the

part of the laboratory we will accept praise for the progress made to make transfusion safer. But, unfortunately, the chief cause of deaths in which transfusion may be involved, is the old blood group system. A or B blood is given to a Group O person. Isn't that a shame? We've had the technical knowledge for 40 or 50 years to solve such a problem in the laboratory, and I believe we have done well, but persons will get the wrong label on a patient's sample; or draw the sample from the wrong person; or mix up persons in the same room or of the same name; or give the well-prepared and cross-matched blood to the wrong patient. As many ways as you can imagine to confuse two persons—all have happened. Please have all who touch the patient in this procedure be careful—you, the nurses, technologists, clinical pathologist, transfusionist — all beware!

Common Reaction

One of the commonest reactions encountered, usually toward the end of the transfusion or shortly thereafter, is the appearance of hives, rash or other evidence of allergic-like lesions. These occur in our experience about five to ten per 1000 transfusions. We feel that if a blood bank doesn't have reports of urticarial reactions to blood transfusions, there may be a lack of knowledge of any reactions which may occur. Allergic reactions are most often due to the constitution of the recipient and less commonly due to reactive properties of the donor blood.

There are means to control or reduce the severity of the allergic and chill and fever reactions to blood. These should be used in patients who require them, and should not be approached by "shot gun" methods. Medications may be given the patient who has a reaction; do not add drugs or other substances to the blood container.

Overload reactions are relatively uncommon. The very young and the old and infirm do not stand rapid administration of whole blood as well as do those who have good cardiac reserve.

We hear no dissident voices when claims are made for the life-saving properties of blood. We join voice with those who would eliminate blood transfusion when other more adequate means are at hand to treat the sick. There is no safety in mishandled blood. All who order it, collect samples, prepare donor blood, crossmatch and transfuse it, have a chance to prevent serious damage to the patient by thinking of what they do. Please insist on a strict discipline here. Reactions which remain when human error is eliminated will be minor and most will be solved by improved technics.

1851 Delaware Parkway

One of the first arts of life is to have no delicacy about money. *George Bernard Shaw*

THE NON-HOSPITAL GENERAL PRACTICE OF MEDICINE

Reid Gullatt, M.D., *Cochran*

The vast majority of medical problems may be diagnosed and treated quite well in the office or in the home.

THE PURPOSE OF THIS PAPER is to invite to the attention of the Medical Association of Georgia a vital part of the practice of medicine which is not mentioned in polite medical circles today. It is imperative that you better understand this type of practice so that you may help it survive. This type of practice is the non-hospital general practice of medicine; and it is conducted, in the words of Dr. Thomas Findley, Chairman of the Department of Medicine at the Medical College of Georgia, by the physician who is willing to go down to the cross-roads and practice good family medicine without doing surgery or obstetrics.

This type practice is vital because it is necessary, and it is necessary because there simply always will be more communities than there can be hospitals. There will always be many communities where doctors must be available but where hospitals may be a few minutes farther off. The Sears Roebuck type of little, all inclusive, community clinic simply has not worked out. There are not the facilities available for emergency care which could be utilized if we concentrated on better equipped offices and higher quality office medicine; and on fewer hospitals which were, in fact, appropriately staffed and equipped and prepared to take care of the unexpected. It is so much more fundamental for a hospital to be truly a hospital rather than simply to be available. Even New York City is currently considering abolishing 28 municipal hospitals in order better to staff its 82 volunteer non profit hospitals and medical school associated hospitals.

I speak to you today from the experience of five years in a new, well equipped office in a small town

without a hospital. I am on the staff of a small, well equipped hospital in a community ten miles from mine, but I soon learned that I was missing really needed problems at home while I was en route to a hospital which had a staff adequate to take care of the job which I was on the way to do. After a family practice is well established in a small community, the sheer volume of the problems which are involved prevents the physician from spending half of this time on the highway.

To be successful in a practice of this nature, one must be transparently honest and must admit that there are many limitations. The truly hospital cases simply must be hospitalized, but it is quite obvious that the vast majority of medical problems may be diagnosed and treated quite well in the office or in the home. Probably the real point of importance to be grasped does embody the fundamental taught in all medical schools: that the justification for the existence of medicine is to treat the patient as a whole. If one can be satisfied with the concept of treating the patient as a human being, he will not be dissatisfied with referring many of his problems which are large or involved, and concentrating on numerous smaller problems to which he needs so desperately to give his time and attention. Good office medicine can be practiced if one will remember these three fundamentals: (1) to allow enough time for your patients (2) to allow enough time for study (3) to allow enough time for yourself and your family. Enough time for one's patients can be gained by good planning and by referring the truly involved problems to the more complex and rapid hospital team. Time for study can be provided by good planning and by regularly taking time off to make ward rounds and attend post graduate meetings. The daily reading of journals and textbooks, of course, is a foregone conclusion in any type of medical practice. One may provide time for his family by frequent week-ends off and by utilizing the easy

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accessibility of leisurely living in the small town.

Some medical educators say that such a practice is not possible; that the problems increase with time and that all the competent men come back and specialize in four or five years. I will agree that most do not stay, but I feel that this is because they do not plan their work to keep from being swamped and because their colleagues do not recognize the importance of their work. Believe me, they would not be swamped if they were not needed, and if we as practitioners of medicine do not provide the service of the physician where it is needed, let us not forget that we are not fulfilling our duty to our fellow man. If you are a successful generalist at the crossroads with several years of fruitful, satisfying practice behind you, enjoying a place of respect and security in your community, the thought of the non recognition of this type practice may not disturb you. It should though, because fewer and fewer of our young physicians are doing it and the future of medical practice as we know it may well hinge on the availability of the family doctor. True socialized medicine and the bureaucratic placement of physicians could well be precipitated by the extinction of this type of practice. In this auditorium three months ago at the Atlanta Graduate Medical Assembly, Dr. Fount Richardson, past president of the American Academy of General Practice, said that there was nothing wrong with medicine in this country that 10,000 more general practitioners could not cure. I concur, but only if half will go to the crossroads.

Why should I burden the physicians of the Medical Association of Georgia with these thoughts? Because we need your help. We need to encourage more young doctors, not only to enter general practice but to do this sort of thing. I participated in Junior Day Ceremonies for the Emory Medical

students last Saturday, and I have for years lectured to the students at the Medical College of Georgia on the necessity of more of them doing the type thing that I am doing.

I personally do not feel that I have signed my professional death warrant by doing this type of practice. My specialist and generalist colleagues respect my practice and my judgment. They help me, but I help them. Since beginning this type of practice, I have published several papers in regional and national journals. One of these papers, "Anaphylactic Shock from a Penicillin Lozenge", was published in *The New England Journal of Medicine* and caused comment from as far away as Israel and Poland. This proves nothing except that good work and clear thinking is not necessarily restricted to board diplomates or medical centers. If we really believe that the day of rugged individualism is not gone and that we don't want to be regimented because we have deserted the people, then let's encourage more of our young men to go to the smaller towns.

In summary, let me remind you that there are many types of general practice just as there are many specialties. The non-hospital general practice of medicine is a vitally necessary part of the practice of medicine, and it is in danger of becoming extinct. We should not accept the thesis that non-hospital medicine is practiced by second rate men in a second rate fashion. We should recognize non-hospital medicine and encourage good men to do a first class job in the small communities and stick to their limitations of training, equipment, and personnel. This will result in a great improvement in medical public relations, and will certainly enhance favorably the much discussed public image of the physician today.

110 East Dykes Street

BIG RISE IN HEALTH MANPOWER

THE NUMBER OF persons employed in the health field is growing rapidly in terms of the country's total manpower, Health Information Foundation reported recently.

In the May issue of *Progress in Health Services*, its monthly statistical bulletin, the Foundation estimated that about 2.5 million people—one out of every 30 persons employed in this country—now work in "health service industries," as defined by the U. S. Bureau of the Census.

According to the Foundation, "The 1960 Census

may very well show that within the last decade the health field has risen from seventh to third place among major U. S. industries in terms of number of persons employed."

Currently about three-fifths of all persons who work in health services industries are connected with hospitals or related institutions. In recent years "there has been an increased diversification and specialization in health occupations, as well as growth in the number of persons college-educated or professionally-trained."

VACCINE THERAPY: A GENERAL REVIEW AND A NEW APPROACH

An evaluation of the method is reviewed and its current application is evaluated.

Jack C. Norris, M.D., *Atlanta*

THE USE OF VACCINES in the treatment and prevention of disease is well documented, and is based on sound physiologic principles. However, beginning at about 1915, the so called "commercial vaccines" began to be used so indiscriminately, that Vaccinotherapy fell under a dark cloud of disrepute. Many physicians who used the vaccines were sometimes referred to as "shot-doctors," which was a very embarrassing, and probably not entirely deserved accolade. Results were also in dispute. But many physicians stick to their impression of the good value of vaccines. That especially applies to several common infections. The autogenous vaccine is again beginning now to be recognized as a valuable adjunct, especially in treating staphylococcal infections.

It is not entirely clear to us as to who it was that first developed vaccines. In all likelihood the credit must go to Louis Pasteur (1822-95). He had utilized bacterial suspensions in preventing and treating cholera, and proved that he could prevent anthrax. As a bacteriologist, he is also credited with discovering the science of microbiology and of vaccination both by using bacteria and attenuated viruses. His monumental contribution was the prevention of

Rabies. During 1903-4 Wright and Douglas were able to demonstrate opsonins, while a bit earlier, Leishmann introduced the opsonic index. Wright advocated this index to be used in guiding the results obtainable in therapy. That work, in which several other famous men were contributors, led almost directly to the use of the Typhoid vaccine, leading on to the introduction of Tetanus Toxoid, in 1934.

The writer had the good fortune in his earlier years to be associated with Dr. G. McF. Mood, of Charleston, S. C., who was the professor of Bacteriology in the Medical School. Dr. Mood was a pioneer in vaccinotherapy, and because of his superb knowledge, had for years made many experiments in an effort to make vaccines that were particularly efficacious. The results Dr. Moody obtained were almost unbelievable, covering many different diseases. Consequently, I was impressed with his work, and have on many occasions followed his technique. But there has always been the difficulty of culturing many of the more fastidious bacteria which he apparently grew easily, probably dependent upon the pH and the enrichment of his mediums. I could not completely reproduce those steps.

In 1935, after entering upon the private practice of pathology and clinical pathology, I was constant-

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ly called upon to make vaccines for various patients, by physicians who were using them rather commonly. However, realizing the fact that so many had proven useless, rather discouraged me. So I set out to try and make some improvements; to shorten the various methods; to experiment with vaccines more closely.

Consequently my observations have, more than ever, now convinced me that vaccines, particularly in Staph and Strep infections, or many of the mixed types, are very useful.

As a rule a short method for making them is described as follows, and is quite good.

"The culture of the material submitted is inoculated inot 10-15 cc.s of sterile broth medium, made from powdered dehydrated brainheart, which when reconstituted has a final pH of approximately 7.4 (DIFCO). As a rule it may be good to use two tubes, and place one of them in an anerobic jar. After 20-24 hours incubation, usually a heavy suspended culture results. The tube is centrifuged, and the concentrate reabsorbed, and re-mixed in 15 cc.s of normal isotonic Saline solution. Smears are then made to recheck the type of bacteria. The Saline suspension is bottled-up in a rubber capped, over-lipping ordinary 15 cc. vaccine vial, to which .15 cc. of a saturated solution of phenol is added. The bottle, with a small hypo needle as a vent, is placed in a boiling water bath, and heated for five minutes, or not more than six. This process of heating always kills the germs. The added phenol protects the mixture from contamination, and also preserves it. The vaccine should be tested for sterility, although I have never had a failure of complete sterilization by the procedure described. Naturally anyone would ask: "Does the boiling injure the antibody stimulating quality of the vaccine?" I do not think so. As far as I can determine, the heat killed suspension gives approximate results when compared with vaccines that have been made by heating them at 60 degrees temperature for one hour, or by using formalin, tricresol, ether or other substances for sterilization. Phenol in small amounts apparently does not produce harm.

Prior to World War II, it was possible in my laboratory, to prepare a vaccine similar to the manner which I have already described, using a more complex culture medium, which was also very effective, and apparently of low reactive toxicity.

The Culture Medium was made as follows:

"One-half pounds each of fat-free, fresh, lean veal meat, and pig or calf brains, were mixed, and run through a grinder. Five hundred to 600 cc.s of distilled water was added, and the substance boiled for five minutes. After cooling it, strain

through a damp, small-mesh laboratory towel. Discard the meat, and to the filtrate, place four grams sodium chloride, and one gram powdered peptone. Titrate with phenolphthalein solution to point 7. or 7.4 pH. After titration, place three grams of dextrose in the solution, and filter through a rapid large porous paper."

The experimental medium is now tubed (10-15 cc.s) in screw-cap type, and sterilized 15 minutes at 15 pounds pressure. When removed from the heater, the medium usually is of a pink-pale yellow color, and is entirely clear.

This solution, when inoculated with almost any variety of ordinary pathogenic bacteria, will obtain a luxurious growth, combined with the presence of finely granular greyish precipitate. This may at times fall to the bottom of the tube, but the substance, whatever it is, is reconstituted in the centrifugate, and mixes nicely with the normal isotonic Saline used in completing the vaccine. As near as I can tell, this is a form of soluble lipo-protein which appears after, or is coincident with the growth of bacteria. It is quite notable in Staph, Strep, and Mic. Catarrhalis cultures. This proteinized mix in some way seems to enhance the value so as to stimulate antibodies, and is not harmful. The vaccine suspension can be killed by boiling for five or six minutes.

Measuring Bacterial Content

After a vaccine is prepared, the question always arises about how best to measure the bacterial content, or to make a suitable solution of it that can be administered safely. There are several different ways of arriving at a dosage: We may use the hemacytometer, or resort to the Wrights' method of computation. McFarland's technique is also popular, and the Hopkins tube more simple to use for this than any other. The bacterial content often ranges from four billion to 10 billion, or any spot between those figures. The first serious principal in vaccine making demands that the bacteriologist be sure of the type bacteria that is in it. Vaccines made from certain varieties of infectious bacteria, for instance typhoid bacilli or other allied group, are very toxic, and cause reactions and pain, including fever or chills. Therefore, any vaccine should be well diluted before its administration. For the ordinary conventional bacteria: Streptococci, Staphylococci, Pneumococci, Micrococci catarrhalis, the amount of growth that will occur in 10 cc. medium will be quite satisfactory for dilution when made up in Saline in the usual 15 cc. vaccine vial, that I have described. Therefore, it is rarely necessary, in my ex-

perience, to go to the trouble of trying to measure ordinary bacterial content.

Considerable experience is necessary, however, when administering the vaccine. It must be borne constantly in mind that a few isolated patients will prove to be allergic. As a rule it is always a cautious procedure to SKIN TEST the patient, administering ONE min., or less, injected into the skin, making a small, elevated, pale swelling about four-five mms. in diameter, then wait for about 15 minutes, requesting the patient to also inform you of any delayed reaction occurring after 24 hours.

Should there be no history in the patient of allergy, asthma or other serious symptoms, the vaccine can be administered without going to this trouble. It is also wise to warn patients of pain, or evening fever, and suggest that aspirin be taken if necessary. As a rule, if there be no interferences, I recommend that a vaccine be administered to the patients about two-three times each week, as directed, in increasing dosage.

The vaccine bottle is to be kept in a cool place, preferably the office or hospital refrigerator. When it is to be given, the vial is shaken thoroughly, and the cap is sterilized with alcohol. With a tuberculin type syringe, graduated in tenths and minims, ONE min. is removed from the bottle, and injected into the skin of the forearm. In about three days another dose is injected, usually two minims. If there has not occurred too much discomfort, the next dose can be injected subcutaneously. It should take several weeks before the amount of one cc. is attained. At that point several spaced cc.s are given, then a rest period is advised until all arm soreness or swellings have become allayed, and the resistance of the tissues have established a state of immunity. It is well known that to stimulate antibodies rapidly, it is preferable to use the intradermal injections. The skin, more than any other tissues, has the highest natural antibody concentration, and that is one reason why the skin is able to withstand ordinary infections. I also inform my patients not to expect dramatic results with vaccine therapy. Doctors, on occasions make the mistake of hoping for a quick result. That, as a rule, does not occur, and it takes, as I have suggested, time for resistance to reach a curative peak.

For a person to say that vaccines are not useful in the treatment and prevention of certain diseases is entirely erroneous. One only needs to recall how typhoid fever and other serious maladies have been

almost completely eliminated by inoculation. But to think that vaccines are not good because they have not been properly prepared and administered is good sense. For instance, I have noted doctors and nurses to pick up a vaccine vial, give it a shake or so, and withdraw the dosage, which is usually only a very diluted quantity coming from the top of the vial; such crude procedures as that can at times account also for overdosage and reaction. It is always a must for the doctor to insist, unless there be reasons against doing so, that the patient continue the dosage until enough of the vaccine has been consumed. So many people quit the treatment after a few "shots," and do not return. In those cases it is but reasonable to assume that unsatisfactory results will occur.

Reaction Controlled With Aspirin

In my years of experience with vaccino-therapy, I am certain of the effectiveness in such conditions as furunculosis, sinus infections, otitis (staph-strep), chronic bronchitis simplex, recurrent boils, and acnes of certain types. On more than one occasion I have been happily amazed at the results, both in acute cases and especially the chronic types. Indeed, I can recall on more than one occasion when a vaccine had probably saved a patient's life. Vaccino-therapy is positively specific in the majority of instances of staphylococcic infections which cause boils.

Simple as these facts may appear to be, there are also certain other factors which either mitigate or enhance the value of the vaccine. First I should emphasize how important it is to make a proper culture. For instance, in culturing boils, it is essential that the skin above the boil be sterilized with alcohol rather thoroughly. Apply the alcohol to the area of intended incision, and wait about five minutes, then gently incise the boil and introduce the culture swab or aspirating needle. The use of some skin antiseptics, and particularly the use of substances of a topical type, will often be the cause of contamination, and the resultant culture would be worthless. In cultures from the mouth, teeth, tongue, nasopharynx or tonsillar regions I like to suggest to the patients that they thoroughly wash the teeth, and rinse the mouth repeatedly with hot Saline solution, followed by applying the culture swab to the affected areas. The cleansing of the mouth and posterior nasopharynx is also very, very important in obtaining uncontaminated sputum for culture. This gives us material from the deeper bronchi which not only is available for growth, but the sputum coughed up,

or obtained on a swab, can be utilized for a Papanacalou smear. If cultures are needed from the nasal passages, I recommend that the outer and inner nasa ali be also cleaned before placing the swab up into the spots where the osita are. Similar care is exercised in culturing the ear and the ear canal. Whenever possible a sterile area aspirated by a needle and syringe are significantly helpful not only in assuring a good clear culture, but makes a contamination unlikely. Rectal cultures are always doubtful of value, as are cultures made from the vagina or cervix, thus indifferent cultures have to be plated-out, and the bacteria which may be thought to be the offending agent, rescued.

During the past 30-40 years many vaccines have been made and used. It seems unfortunately to be, that most of the claims of both good and bad results have been claimed on very poor evidence, rather a hit or miss calculation. On the other hand good reports are emerging that have had an adequate scientific back-ground. Many of my results, or the results that other doctors have obtained, from vaccines prepared in my laboratory, have been based largely on the results reported both by the doctor and the patient. In one series 200 cases were followed, and it was my impression that at least 80 percent of the patients reported beneficial effects.

Recently in the JOURNAL, ACTIVE PRACTITIONER AND DIGEST OF TREATMENT, July 1960, Doctor Merrill Lineback¹ made a report on the use of vaccines in Staphylococcal Infections of the Head and Neck. Those vaccines were made in my laboratory. His conclusions were of considerable interest. He found that out of 88 cases, he obtained cures in 53, a conservative percentage of about 60 per cent.

In the J.A.M.A. September 3, 1960, McCoy and Kennedy² reported 60 Staphylococcal infections which were treated with vaccines, with the following figures: five cases failed; 11 improved, and 44 had an excellent response. These doctors attributed their good percentage as probably due to the manner in which the vaccines were sterilized. Heat was not used, and the vaccine culture was inhibited by adding Benzylkonium Chloride solution, 1-1000 strength of which 2.5 cc.s were added to 15 cc. of the Saline suspended vaccine mix. Those authors also are of the opinion that heat in part destroys some of a vaccines ability to stimulate antibodies. I do not believe this. Their methods of production may well prove to be an improvement.

It would appear therefore, vaccines will become quite popular in the future, more than they have in the past. When we recall that so many otherwise aids, such as the exciting antibiotics have proven

deficient. I am sure, however, there are certain antibiotics that will continue to be helpful, such for instance as Chloromycetin, Pan Alba, Albamycin Erythrocin, Tao and Declomycin, in that order. Furadantin and Humatin are very effective. Some of the newer penicillins also show great promise. The antibiotics can be used in conjunction with specific vaccines when necessary, unless there be allergy, and the combination treatment is often sensational in results.

Further Development

The final few remarks which I want to make, while not a special topic in this paper, permit a comment or two regarding further vaccine development. Such as, for instance, in treating or preventing Cancer. We can readily admit the efficacy of Polio vaccines, and Cancer vaccines can only be a step further along. An effective Cancer vaccine would depend largely upon strong antibody formation in the blood and lymphatic systems. Friend³ has demonstrated such antibodies in leukemia-like maladies, confirmed by Schwartz and his associates⁴ of the presence of similar immune bodies in mice suffering with leukemia. Those demonstrations are stepping stones to greater efforts.

In a recent paper by Graham and Graham,⁵ methodology was prepared for producing vaccines for Cancer patients by using Freuends adjuvant to promote and enhance an immune response. In a series of patients with poor outlook 55 out of 101 cancerous victims lived seven months or longer, a result that is most encouraging, and suggests that future investigations along this line may be of prime importance in conquering cancer in the human.

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MANAGEMENT OF HYPERTENSIVE PATIENTS WITH TRICHLORMETHIAZIDE AND RESERPINE

Robert J. Starling, M.D., *Donaldsonville*

This combination was well tolerated and effective in 26 patients with hypertension and five women with pre-eclampsia.

THE BENZOTHIADIAZINE DIURETICS are of great value in the management of hypertension because of their ability to lower blood pressure without significant side effects even when there is associated cardiac disease or secondary renal impairment. This class of drugs might exert their antihypertensive effect as a consequence of naturesis or through a specific mechanism of action, unrelated to reduction of extracellular fluid, which decreases resistance of the arterial walls.¹ Refractoriness after relatively brief therapy, a serious disadvantage of pure carbonic anhydrase inhibitors, rarely if ever occurs with the benzothiadiazines.² Combination of a benzothiadiazine diuretic with another antihypertensive drug, typically reserpine, often provides optimal results because depletion of excess sodium enhances the effect of drugs which depress the sympathetic nervous system.^{1,3-5}

Reserpine is used widely in the treatment of hypertension and its properties are well known. Central sympathetic influences are inhibited, anxiety is diminished, and the heart rate usually is slowed.⁴ The tranquilizing effect of reserpine is an advantage in most hypertensive patients who are likely to be caught in a vicious cycle of anxiety favoring hypertension and hypertension causing anxiety.³

One of the newer benzothiadiazine diuretics is trichlormethiazide (Naqua®). Its chief advantage over older analogues is a decreased tendency to cause potassium loss at doses which are equipotent

for sodium excretion. Ford⁶ tested this drug in patients under precise metabolic control and found that it predominantly caused excretion of sodium. There was a slight increase in the excretion of potassium and bicarbonate over pretreatment values but the increase was less than that provoked by the older benzothiadiazines. Although increased loss of sodium persisted until all excessive stores were lost, increased potassium excretion did not occur after the first few days of therapy. There was no significant effect on the serum electrolytes. Hutcheson and Takasu⁷ found that administration of 16 mg. trichlormethiazide daily was followed by a slight but not significant decrease in the level of serum potassium and a slight reduction of the serum osmolality. There was no effect on the serum pH, serum carbon dioxide combining power, serum creatinine clearance, or glomerular filtration rate. Trichlormethiazide does not affect the renal plasma flow.²

Clinical studies indicate that trichlormethiazide is optimally effective at doses of four to 16 mg. daily.^{6,7} It has a pronounced antihypertensive effect alone or in combination with reserpine.^{6,8}

Materials and Methods

Tablets containing combinations of trichlormethiazide and reserpine were administered to 26 patients with hypertension and five women with pre-eclampsia. Five patients who did not have hypertension or other systematic disease agreed to take the tablets for brief periods so that any untoward effect in normal subjects could be discovered.

Of the 26 patients with hypertension, (160/80 mm. Hg or greater) one had hyperthyroidism, two females had the menopausal syndrome, and 12 patients had some type of associated heart disease, usually arteriosclerotic. Edema was present in eight patients. Laboratory studies indicated some degree

* These compounds are now available as Naquival-2® and Naquival-4®. A supply for investigation was provided by W. Wesley Herndon, M.D., Medical Research Division, Schering Corporation, Bloomfield, New Jersey.

of renal impairment in ten patients.

All but seven patients had typical signs and symptoms of hypertension. The others were essentially asymptomatic and elevated blood pressure was discovered during routine examination or treatment for an unrelated disease.

Twelve hypertensive patients had been treated previously with reserpine (Serpasil® or Raudixin®), hydralazine hydrochloride (Apresoline®), mannitol hexantrate (Nitrantol®), of phenobarbital sodium (Luminal®). The response had been good in three, poor in two, and fair or variable in seven. Four patients gave a history of previous treatment by other physicians with unknown drugs and therefore were evaluated as "previously untreated"; ten had had no previous treatment.

The diagnosis of pre-eclampsia was based on elevated blood pressure (150/90 mm. Hg or greater), rapid weight gain, mild or moderate edema, and subjective symptoms such as dizziness. Laboratory studies yielded essentially normal results except in two patients with albuminuria, one of whom also had pyuria and mild hypochromic anemia. Four patients had no history of hypertension; the fifth had become hypertensive during two of her 13 previous pregnancies.

Two compounds were used.* Each tablet of compound A contains two mg. trichlormethiazide and 0.1 mg. reserpine and each tablet of compound B contains four mg. trichlormethiazide and 0.1 mg. reserpine. Compound A was administered to 12 patients with hypertension, the five patients with pre-eclampsia, and two normal subjects; compound B was administered to 14 patients with hypertension and three normal subjects. The dosage was two or three times daily. The duration of treatment (except in the normal subjects) ranged between two and 15 weeks and averaged six weeks. The normal subjects received the tablets twice daily for two or four weeks.

Results

The results in the previously untreated patients with hypertension are shown in Table 1. After two to 15 weeks of treatment, no patient had edema and ten of these 14 patients had normal blood pressure (not greater than 140/80 mm. Hg). There was no hypotension; the lowest value was 112/80 mm. Hg. The mean reduction was 44/18 mm. Hg. All patients also lost weight as a result of diuresis; the mean loss was 11 pounds.

TABLE 1
Effects in 14 previously untreated hypertensive patients

Age and Sex	Daily Dosage	Duration of Treatment	Pretreatment Laboratory Findings	Edema		Blood Pressure		Weight		Pulse	
				Before	After	Before	After	Before	After	Before	After
39; F	B-bid	5 weeks	negative	-	-	178/98	130/70	131	127	88	84
66; F	B-tid	3 weeks	negative	-	-	200/100	180/80	163	157	88	84
60; M	B-tid	15 weeks	albuminuria + + + +	+ + + +	-	240/140	188/100	245	180	104	104
65; M	B-bid	4 weeks	albuminuria + + pyuria + + + +	+	-	210/110	130/80	192	187	92	80
71; M	B-bid	12 weeks	negative	++	-	210/110	120/70	187	175	92	80
36; F	A-bid	10 weeks	hemoglobin 11.8 leukocytes 18,000	-	-	160/100	112/80	143	138	88	72
43; F	A-bid	7 weeks	negative	-	-	176/92	136/80	129	125	84	80
53; F	A-bid	5 weeks	negative	-	-	160/92	130/80	142	141	104	84
55; F	A-tid	13 weeks	albuminuria +	++	-	200/80	140/80	188	165	104	80
59; F	A-bid	5 weeks	negative	-	-	180/90	140/80	146	141	80	80
26; M	A-bid	2 weeks	albuminuria + + PSP 35% 2 hrs.	-	-	180/90	176/90	141	139	88	84
46; M	A-bid	3 weeks	negative	-	-	176/100	140/80	168	165	84	84
48; M	A-bid	6 weeks	negative	-	-	190/90	140/80	190	188	88	80
70; F	A-bid	8 weeks	albuminuria + + + + erythrocytes 3,600,000 leukocytes 11,400 ESR 31 mm.hr.	+	-	162/90	146/80	168	162	88	84
Summary (mean changes)						-44/18		-11		-8	

HYPERTENSIVE PATIENTS / Starling

The results in the 12 hypertensive patients who had previously received other antihypertensive drugs are shown in Table 2. Previous results had indicated that these patients, in general, are resistant to therapy. Results were generally good although not as dramatic as those in the first group. There was a mean reduction of 24/15 mm. Hg. although only two patients had normal blood pressure after two to 11 weeks of therapy. These patients lost an average of five pounds as a result of diuresis and no patient had edema after treatment.

Treatment was considered satisfactory if the blood pressure decreased gradually to relatively normal and if presenting signs and symptoms were substantially relieved. This occurred in 18 of the 26 patients. The result of treatment was considered fair in six patients who showed some decrease of the blood pressure but not to a desirable level. In two patients, treatment failed to bring about significant improvement. One was the patient with hyperthyroidism, for whom surgery was performed later. The other patient, with arteriosclerotic heart disease, did not have either a diuretic or antihypertensive response.

Case Report

A male of 60 years had been hypertensive for at least 12 years with recurrent episodes of edema.

The patient was hospitalized with anasarca, massive edema, and numerous signs and symptoms of hypertensive cardiovascular disease. The blood pressure was 240/140 mm. Hg, the weight was 245 pounds, and the pulse rate was 104. There was massive cardiac and hepatic hypertrophy and severe albuminuria with formed elements. This patient was treated with injections of one cc. meralluride (Mercurhydrin®) on alternate days and compound B three times daily. During two weeks of hospitalization, there was a gradual loss of fluid and reduction of blood pressure. At discharge, there was a weight loss of 49 pounds, the liver was of normal size, the edema had disappeared, and the blood pressure had dropped 20 mm. Hg. The patient was then treated on an ambulatory basis with only compound B three times daily for two months to date. Supplementary potassium chloride was given because the serum potassium level had dropped slightly. The blood pressure is now 188/100 mm. Hg. (a reduction of 52/40 mm. Hg.) and the weight is 180 pounds (a reduction of 65 pounds). There is no edema and the patient is reasonably comfortable.

Case Report

A female of 41 years presented hypertension (190/110 mm. Hg), moderately severe dependent edema, and mild renal damage. There was a history of rheumatic heart disease during childhood and recurrent episodes of cardiac failure which had been

TABLE 2
Effects in 12 previously treated hypertensive patients

Age and Sex	Daily Dosage	Duration of Treatment	Pretreatment Laboratory Findings	Edema		Blood Pressure		Weight		Pulse	
				Before	After	Before	After	Before	After	Before	After
29; F	B-tid	4 weeks	PBI 11.6 μ	-	-	220/130	210/120	161	159	136	120
41; F	B-tid	3 weeks	PSP 40% 2 hrs. CT 21 sec.	+++	-	190/110	140/84	161	146	92	80
50; F	B-tid	3 weeks	negative	++	-	210/100	190/80	188	174 1/2	88	84
56; F	B-tid	4 weeks	negative	-	-	170/100	156/84	161	155	88	84
57; F	B-tid	8 weeks	albuminuria +	-	-	190/120	150/90	161	154	84	84
60; F	B-bid	2 weeks	negative	-	-	190/70	170/80	146	143	88	88
67; F	B-bid	11 weeks	albuminuria +	+	-	200/130	190/120	181	180	88	84
72; F	B-bid	2 weeks	negative	-	-	188/90	160/80	143	136	84	84
82; M	B-tid	6 weeks	albuminuria +++ PSP 35% 2 hrs.	-	-	240/140	230/120	140	140	88	88
62; F	A-bid	3 weeks	negative	-	-	190/110	188/100	141	140	96	92
47; M	A-bid	4 weeks	negative	-	-	186/94	130/80	137	136	84	84
68; M	A-tid	4 weeks	albuminuria +++	-	-	230/110	200/90	162	159	88	84
Summary (mean changes)						-24/15		-5		-4	

TABLE 3
Effect in five pre-eclampsic patients

Age and History	Daily Dosage	Duration of Treatment	Pretreatment Laboratory Findings	Edema		Blood Pressure		Weight		Pulse	
				Before	After	Before	After	Before	After	Before	After
16 G1 Po 6th month	A-bid	8 weeks	albuminuria ++ pyuria +++++ hemoglobin 11.2	++	-	150/90	120/70	128	126 1/2	80	80
18 G1 Po 5th month	A-bid	12 weeks	albuminuria +	++	-	162/94	120/60	167	163	80	80
18 G1 Po 6th month	A-bid	7 weeks	negative	+	-	160/88	120/70	126	122	78	72
31 G2 P1 4th month	A-bid	8 weeks	negative	+	-	150/90	120/70	139	136	84	84
36 G14 P13 7th month	A-bid	9 weeks	negative	-	-	150/90	110/70	165	161	80	80
Summary (mean changes)						-36/-22		-3		-1	

treated with reserpine, mercurial diuretics, and digitalis. The pulse was 92 and the weight was 161 pounds. Compound B was administered three times daily for three weeks. The blood pressure decreased gradually to 140/84 mm. Hg, there was a weight loss of 15 pounds, and the patient was free from edema. There were no side effects of therapy.

The five patients with pre-eclampsia responded very well to treatment (Table 3). The blood pressure decreased to normal limits (not greater than 120/70 mm. Hg.), diuresis reversed the edema, and patients lost an average of three pounds of weight despite several months' advancement of pregnancy. Therapy was continued until term and these five patients remained in a satisfactory condition until delivery, which was uncomplicated in all cases.

Case Report

A female of 16 years entered the fifth month of pregnancy in a satisfactory condition except for al-

buminuria and pyuria. However, within one month the blood pressure rose from 130/70 mm. Hg to 150/90 mm. Hg and she gained ten pounds. There was moderate edema and the patient complained of dizziness. Compound A was administered twice daily and after two weeks edema disappeared, she lost six pounds (presumably fluid), and the blood pressure decreased ten points. After two months of treatment the blood pressure was 120/70 mm. Hg, the weight was normal, and the clinical condition was satisfactory. The patient was maintained on this regimen until normal delivery.

Results in five normal subjects (Table 4) indicate that the compounds do not depress blood pressure in normotensive individuals. There were no abnormal findings in this group after administration.

There was no side effect of treatment except nasal congestion, attributable to reserpine, in four patients.

TABLE 4
Effects in five normal subjects

Age and Sex	Daily Dosage	Duration of Treatment	Blood Pressure		Weight		Pulse	
			Before	After	Before	After	Before	After
31; F	A-bid	2 weeks	130/70	120/70	184	182	80	80
18; M	A-bid	2 weeks	132/76	130/78	142	142	80	80
19; F	B-bid	2 weeks	130/68	120/70	169	169	80	80
28; F	B-bid	4 weeks	120/70	120/70	142	141	76	72
32; M	B-bid	2 weeks	120/80	120/80	182	182	72	72
Summary (mean changes)			-4/0		-1		-1	

Conclusions

Trichlormethiazide is a very efficient oral diuretic agent and in combination with reserpine is of value for the management of hypertension of various etiologies. Even in progressive hypertensive cardiovascular disease, the combination provides good control for long periods of time. The reduction in blood pressure is gradual and usually continues until a reasonably normal level is reached. Lower doses can be used to maintain pressure at a desirable level. The combination also rapidly relieves symptoms of congestive failure such as dyspnea, orthopnea, and edema.

Small amounts of trichlormethiazide and reserpine are effective when administered together because their antihypertensive action is complementary. The risk of side effects from either agent is therefore minimal.

Summary

Trichlormethiazide, two or four mg., and 0.1 mg. reserpine were administered in combination two or three times daily to 26 patients with hypertension, usually also with cardiac disease and renal impairment, and five patients with pre-eclampsia. The

mean reduction in blood pressure in these 31 patients was 35/17 mm. Hg after two to 15 weeks of treatment. Other signs and symptoms, especially edema when present, also were rapidly relieved. The combination did not lower blood pressure in five normotensive subjects. The only clinical side effect was nasal congestion in four patients and there was no evidence of toxicity.

Box 234

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2. Fuchs, M.; Moyer, J. H., and Newman, B. E.: Human Clinical Pharmacology of the Newer Diuretics: Benzothiadiazine and Phthalimidine. *Ann. New York Acad. Sc.* 88:795-808, 1960.
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Georgia Heart Association Approves 16 Grant-In-Aids

THE GEORGIA HEART ASSOCIATION has approved 16 grants-in-aid for research, bringing to more than one million dollars the total amount the association has allocated for research on state and national levels since 1950.

This announcement was made by Dr. Arthur M. Knight, Jr., of Waycross, who is president of the heart association.

"The 16 grants will be financed in Georgia medical institutions by a record annual appropriation of nearly \$107,000," he said, pointing out that an additional \$69,879 will be directed to the American Heart Association's national research activities.

"American Heart also awards research grants in Georgia, exclusive of those provided each year by the Georgia Heart Association," Dr. Knight said.

The Waycross internist said that seven of the 16 GHA grants will support research in new areas, including the development of an effective heart-lung-

kidney apparatus and studies on coagulant defects, pulmonary oxygenation, renal insufficiency, valvular regurgitation and the influence of acidosis on phosphorus metabolism.

He said that the other nine grants are renewals of projects already underway.

The 16 grants have been assigned to institutions and research scientists as follows:

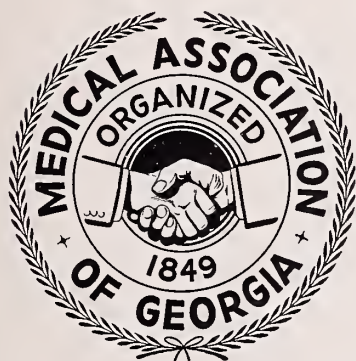
Emory University, Atlanta: Dr. Elbert P. Tuttle (2), Dr. Robert C. Schlant (2), Dr. F. Kathryn Edwards and Dr. Pierre M. Galletti.

Medical College of Georgia, Augusta: Dr. J. Edwin Wood, Dr. Lois T. Ellison (2), Dr. Edwin E. Brackney, Dr. Robert G. Ellison, Dr. Thomas Findley and Dr. Walter R. Stern.

Georgia Baptist Hospital, Atlanta: Dr. William D. Logan. St. Joseph's Infirmary, Atlanta: Dr. James B. Minor. Piedmont Hospital, Atlanta: Dr. Spencer S. Brewer.

1962 Annual Session

May 6-9, 1962—Savannah, Georgia



Second Call for Scientific Papers

All titles must be submitted to the
respective program chairmen listed
below before November 1, 1961.

ANESTHESIOLOGY

R. L. Stone, M.D.
5737 Colonial Drive, Savannah

CHEST

John L. Elliott, M.D.
212 E. Huntingdon Street, Savannah
J. L. Alexander, M.D.
104 E. Gwinnett Street, Savannah

DERMATOLOGY

Vincent J. Cirincione, M.D.
800 Abercorn Street, Savannah

DIABETES

Jules Victor, M.D.
5 Medical Arts Center, Savannah

GENERAL PRACTICE

T. A. Peterson, M.D.
11 W. Jones Street, Savannah

MEDICINE

Fenwick Nichols, M.D.
12 Medical Arts Center, Savannah

OBSTETRICS AND GYNECOLOGY

Henry C. Frech, M.D.
2 Medical Arts Center, Savannah

OPHTHALMOLOGY AND OTOLARYNGOLOGY

W. W. Buckhaults, M.D.
905 Abercorn Street, Savannah

ORTHOPEDICS

T. A. Amburgey, M.D.
8 Medical Arts Center, Savannah

PATHOLOGY

H. L. Howard, M.D.
Memorial Hospital, Savannah

PEDIATRICS

Milton Mazo, M.D.
4 Medical Arts Center, Savannah

PSYCHIATRY

A. H. Center, M.D.
10 Medical Arts Center, Savannah

RADIOLOGY

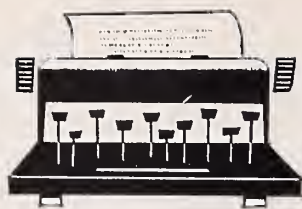
David Robinson, M.D.
P. O. Box 394, Savannah

SURGERY

J. R. Winburn, Jr., M.D.
24 E. Liberty Street, Savannah

UROLOGY

Irving Victor, M.D.
228 E. Huntingdon Street, Savannah



editorials

General Practitioners Convene 13th Annual Session Next Month

FOR THE PAST 12 YEARS the Georgia Academy of General Practice has convened their Annual Session with over 100 general practitioners in attendance. This year the Academy's 13th Annual Session promises to be "something special."

Choosing the Golden Isles as the site of the 1961 GAGP meeting, Jekyll Island has facilities galore for physicians, their wives and children. The new Aquarama provides ample space for scientific meetings and exhibits. This air-conditioned glass and concrete structure will be the center of GP meeting activity on Jekyll.

This GAGP meeting to be held October 12, 13 and 14, 1961 has been designed especially for the fellowship that goes with any scientific session. Departing from the usual two-day 9 A.M. to 5 P.M. schedule of meetings, this session will meet from 9 A.M. to 1 P.M. for three consecutive days. The scientific program subjects were selected to empha-

size medicine the first day; surgery the second day; and obstetrics and pediatrics the final day.

Two brief business sessions for Academy members are scheduled at the opening of the meeting and the final day of the sessions. A highlight of G.P. activity is the President's Banquet which will be a "Luau Feast" in the motif of Georgia's Golden Isles.

Although not planned as a "must," arrangements have been made for golf, fishing and even deep sea fishing, etc. There are many delightful activities planned for physicians' wives. Motel and hotel accommodations are "first rate" and ample reservations are available.

The theme of the meeting has been described as "postgraduate education by the seashore" and all physician members and non-members are heartily encouraged to mark their meeting calendar for Oct. 12, 13 and 14.

Poliomyelitis — 1961

AS WE GO TO PRESS this mid-August our thoughts turned toward poliomyelitis. This year as in the past Georgia has been in the forefront of new and exciting progress in the conquest of this crippling disease. During the spring Columbus, Georgia was the

scene of a highly successful demonstration of mass immunization using Salk vaccine. The methods for community mobilization employed there were incorporated into a motion picture by the Communicable Disease Center which has been shown widely

throughout the country in support of the national campaign for polio immunization of "Babies and Breadwinners."

In Atlanta, in June, we have seen a threatened epidemic of Type III poliomyelitis successfully aborted by the prompt joint leadership of State and local health authorities with organized medicine in the five-county metropolitan area. Monovalent Type III oral vaccine, generously contributed by Dr. Albert B. Sabin, was given with a remarkably broad community response in all population groups. A followup survey by the CDC revealed that many children, particularly toddlers and preschoolers in the crowded central area of the city, were immunized for the first time. In the six weeks since this mass program only a few scattered cases of paralytic poliomyelitis have occurred, all among that small residual group of children who for some reason failed to take the oral vaccine.

We called the CDC to get the latest in the national scene because the Poliomyelitis Surveillance Unit established there in 1955 is the nerve center for polio control in the whole country. We learned some wonderful news. To date, August 10, 1961, has been a record low year. Never, since polio reporting began in 1912, has the incidence rate in the first seven months of the year been so low. Only 234 paralytic cases have been reported up to August 5. While the epidemiologists at CDC warn that it is too soon to gloat as epidemics, even serious ones, could still develop, there is much reason for optimism. Particularly significant is the absence of a single known epidemic focus in the country at this time.

Looking to the future the CDC epidemiologists are both optimistic and worried. They foresee the possibility of a continued long term decline in incidence of paralytic polio, but they fear disturbing interruptions such as occurred in 1958 and 1959. Some epidemiologists believe that adequate immuni-

zation with the Salk vaccine has actually limited the natural spread of the polioviruses in the community. Type II virus has essentially disappeared. This year the early laboratory reports on the few cases that have occurred indicate that Type III predominates throughout the country as well as in Atlanta. The conclusion is tempting that Type I is also on the way out. Will Type III promptly follow?

When the oral vaccines become generally available, which we hope will be soon, further limitation on the spread of all wild virulent viruses will be possible. Hence the optimism.

The worry of the CDC is that continuing immunization of the population will not be sufficiently general, widespread or uniform. Unless we all are constantly vigilant we will permit "islands" of unimmunized infants and preschool children to develop. It becomes increasingly important to attain high levels of immunity in all segments of the population at a very early age. The babies keep coming along. Natural immunization from the silent spread of wild viruses which formerly was the common means of protection of a large part of our population now no longer will be working for us. Unless we are careful and thorough we may see in the years to come localized concentrated epidemics of great intensity among these ignored or overlooked "islands" of children who have not been adequately immunized.

If such occur they can probably be aborted by prompt action. An epidemic reserve of oral vaccine was planned set aside by CDC for this and other purposes. The necessity of careful surveillance of all cases of aseptic meningitis and suspicious neurological disease is obvious. The need for prompt and adequate facilities for laboratory confirmation of diagnosis and epidemiological investigation of sources is evident. Most important of all, however, is the continuing need for adequate immunization of all infants before their first birthday.

M.A.G. Program Chairmen Plan Scientific Session

YOUR ASSOCIATION MUST RECOGNIZE those physicians who serve—and give credit wherein credit is due. To this end, it is proper that the MAG Annual Session Specialty Society Program Chairmen are commended for their activity in arranging the scientific meetings of MAG.

Each year, some nine months prior to an MAG Annual Session, some 15 Georgia specialty societies

appoint a physician living in the town chosen for MAG's meeting—to program the section or joint section meeting in the interests of his specialty. These section chairmen schedule all scientific presentations. They receive requests from Georgia physicians to present papers and select out-of-state speakers to make additional presentations.

Working jointly with the chairmen of other speci-

ality sections, joint section meetings are arranged and papers of interest to all specialties involved are scheduled. And through the efforts of these dedicated chairmen, MAG scientific programs are completed and blended to make the MAG Annual Session the best postgraduate education in the state.

The following section and joint section meetings for the 1962 Savannah MAG Annual Session have been set:

Sunday afternoon, May 6—2:30 P.M. to 5:00 P.M.

Pediatrics and Surgery Joint Meetings; Dermatology and E.E.N.T. Joint Section Meeting; Anesthesiology Section Meeting; Radiology Section Meeting; and Orthopedic Section Meeting.

Monday morning, May 7—9:00 A.M. to 12:00 NOON.

Chest, Diabetes, Medicine and Psychiatry Joint Section Meeting; Obstetrics, Urology, Pediatrics and Surgery Joint Section Meeting; and Radiology, Or-

thopedics and Pathology Joint Section Meeting.

Tuesday morning, May 8—9:00 A.M. to 12:00 NOON.

G. P. Day—MAG General Session (Scientific).

Tuesday afternoon, May 8—2:30 P.M. to 5:00 P.M.

General Practice and Psychiatry Joint Section Meeting; Medicine, Chest and Diabetes Joint Section Meeting; and Obstetrics Section Meeting.

There are many other scientific and business meetings scheduled in addition to the above "skeleton" program such as all the Specialty Society business meetings, dinners and luncheons.

There is no doubt that the 15 section program chairmen work and work hard at designing scientific presentations of merit. "Good programs do not come easy" and we owe the 15 physicians a debt—a debt that can be balanced by attending these meetings so that their efforts are meaningful.

Who are the MAG Specialty Society Program Chairmen? Let's look at page 447, in this issue of *JMAG* so that we may give credit where credit is due.

Seabathers Eruption

BECAUSE OF MODERN TRANSPORTATION, diseases not native to Georgia are from time to time seen here. A peculiar skin condition, Seabathers Eruption, is seen in Georgia in the summer months—the affliction having been contracted in sea water—usually off the Florida coast

Seabathers eruption has a very characteristic appearance and course. The bather experiences intense pruritis in the distribution of his bathing suit soon after leaving the water. After a few hours a papular or pustular eruption develops in that area associated with intense itching. The condition, untreated, runs its course in a few days and is uncomplicated.

The cause of the eruption is not known, however, it is suspected that some ocean organism is the cause. It was at one time suspected that cercariae of ocean schistosomes were the causative organisms, as the eruption resembles "Swimmers Itch" which is caused by contact with schistosome cercariae.

The eruption can apparently be prevented if the bathing suit is removed soon after leaving the water and the skin thoroughly dried.

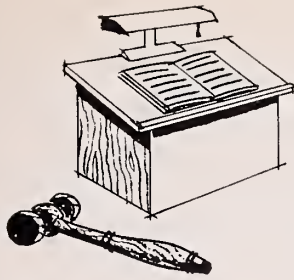
Treatment is symptomatic, with topical antipruritic lotions usually sufficing. In the severe case, oral steroids for a few days bring gratifying relief.

Frederick F. Hardin, M.D.

\$1,000 AWARDS IN UROLOGY CONTEST

The American Urological Association offers an annual award of \$1,000 (first prize of \$500, second prize \$300, and third prize \$200) for essays on the result of some clinical or laboratory research in Urology. Competition is limited to Urologists who have been graduated not more than ten years, and to hospital internes and residents doing clinical or laboratory research work in Urology. Animal research is not necessary.

"The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Bellevue—Stratford Hotel, Philadelphia, Pennsylvania, May 14-17, 1962. "For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, 1, Maryland. Essays must be in his hands before November 15, 1961."



president's letter



FRED H. SIMONTON, M.D.

MAG MAPS FUTURE PLANS

IT HAS BEEN SAID that the noted 16th century French physician and astrologer, Nostradamus, possessed the power to foresee the future and predict with some accuracy events which would occur. The validity of this claim is open to serious doubt and certainly no physician today would lay claim to such a gift.

In the absence of such extraordinary metaphysical powers, physicians like other people, try to prepare for the future, not with a crystal ball, but by blending together imagination, historical precedent and just plain old fashion hard work to arrive at a fairly accurate estimation of what the future holds.

The Executive Committee of Council of MAG has attempted to apply these same standards in order to answer several basic questions relative to the future of our Association and the medical profession in general.

It was recently my pleasure to host the members of the Executive Committee at my farm in West Georgia to what we termed a "big think" meeting. For the first time in the history of MAG, the Executive Committee gathered for the expressed purpose of analyzing what appears to be trends with a view toward coming to certain conclusions of a long range nature. In short, we were attempting to

solve problems which have not yet occurred. We were taking a long, hard look at the Medical Association of Georgia in an effort to determine if we could foresee any danger spots or any areas in which extra effort and increased attention should be applied.

Among the areas probed at this meeting were (1) the Annual Session, (2) health care of the aging, (3) political and legislative matters, and (4) liaison with allied health organizations.

It was generally agreed to by the members of the Executive Committee that there should be additional meetings of this type. Their importance as an administrative tool was felt to be self evident.

Those in whose hands has been trusted the reins of leadership know that from time to time activities of the Medical Association of Georgia must be picked apart, examined, patched where needed and put back together again. Such critical self analysis helps to sand off the rough edges which tend only to irritate the day to day operation of the Association.

In recent times it has become increasingly clear that the long range objectives, like the day to day and month to month operations of MAG, must occasionally be held up to the bright light of truth.

PRESIDENT'S LETTER / Continued

For without a clear cut, well defined long range objective in mind, organizations as large and complex as ours could conceivably wander off course.

Short sighted, narrow gauge leadership is roughly the equivalent of no leadership at all. Today's problems, particularly those facing organized medicine, require peripheral and far sighted vision by all those attempting to find solutions. Anything less than this would result in a policy of merely check-mating problems as they arise. This is a luxury we cannot afford, for in the end we would accomplish few, if any, of the objectives which justify the existence of our Association in the first place.

The New England poet, Robert Frost, once remarked that he "charged more for prophecy than

he did for history." With this casual utterance he underscored the difficulty of forecasting future events. It is not an easy task. At best it will never be an exacting art. Your Executive Committee welcomes expressions of opinion and disclosure of facts from the membership of MAG. Feel free to do this at any time either through personal correspondence or through your representative to the House of Delegates.



President, Medical Association of Georgia

COUNTY SOCIETIES HOLD BREAKFAST MEETINGS TO DEFEAT KING BILL

Speaking before the AMA Legislative Conference in Chicago last March, Senator Robert Kerr remarked that "doctors could keep their business out of politics, but they could not keep politics out of their business." With this remark he brought home to the medical profession what businessmen have been painfully aware of for the past 20 years or more.

The threat of interference by the federal government into the lives and livelihoods of professional and business groups has produced a common bond of interest between the two. As this threat relates to medical aid for the aged under Social Security, responsible businessmen have demonstrated a concern equal to that of the medical profession over the possible enactment of H.R. 4222, the King bill.

Doctors Enlist Support Against King Bill

Acting on the basis of this common concern for the defeat of the King bill, several county medical societies have sponsored breakfast meetings which were attended

by leading business and professional people from the counties in which these breakfasts were held.

The purpose of these meetings, of course, has been to alert the business community to the dangers inherent in the King bill and to gain their support for our position regarding this bill. Such breakfast meetings to date have proven to be tremendously successful in accomplishing these goals.

MAG applauds this positive approach and commends it to every county medical society in the state.

Format for Success

The format for a successful medical-legislative breakfast is extremely simple and to sponsor such a meeting requires very little time and effort.

First, a general chairman should be appointed to coordinate this activity. Secondly, a committee of two or three doctors should prepare a guest list; invitations then should be issued, first by telephone, followed up by a short note to reach the guest a few days prior to breakfast.

Arrangements must, of course, be made to secure a dining room of such size and quality as to insure a smoothly held meeting. Speakers must then be obtained.

Your Headquarters Office is ready at any time to be of every possible assistance to any county medical society sponsoring a medical-legislative breakfast. Such assistance would naturally include securing speakers, printing agendas, supplying handout literature, advising on any aspect of the breakfast meeting, and in providing any service designed to enhance the success of such meetings.

MAG encourages each county medical society to give serious consideration to holding such a breakfast meeting. They have been most successful to date and they will continue to create an atmosphere in which politicians would find it difficult justifying the enactment of H.R. 4222, the King bill.

For detailed information on how your county society can sponsor a medical-legislative breakfast contact YOUR Headquarters Office in Atlanta.



Among the leading business people to attend the Bibb County Society's July 26th breakfast is Peyton Anderson (third from right), Publisher of morning and evening newspapers in Macon. Pictured from L to R: Richard Nelson, AMA Chicago, Drs. Hatcher, Neal, Mr. Anderson, Dr. Birdsong, Mr. Reginald Trice, Board Chairman, Piedmont-Southern Life Ins. Co.



legal page

NATUROPATH'S CONVICTION AFFIRMED

John L. Moore, Jr., *Atlanta*

A VERY RECENT DECISION of the Court of Appeals of the State of Georgia dealt with the interesting question of the illegal practice of medicine by a naturopath.

Evidence at the trial for a misdemeanor showed that the naturopath had not been issued a license to practice medicine by the State Board of Medical Examiners. The evidence further showed that he had, over a period of several years prior to the trial, treated patients for high blood pressure, influenza, bad tonsils, pregnancy, common colds, and other maladies. Evidence presented by a pharmacist at the trial showed that the naturopath had filled approximately 3,000 prescriptions over a two-year period. The naturopath had prescribed bicillin, diamox, pyridium, seconal, equanil and other drugs. Testimony of patients showed that he had treated his patients on occasions by giving hypodermic injections and that he was paid various sums of money for the treatment of the patients.

Other evidence presented at the trial, according to the Court of Appeals, justified the jury in finding that the defendant naturopath had held himself out to the public as being engaged in the practice of medicine. He had used prescription blanks with his name preceded by the term "Dr." typed or printed on the blank.

Both the druggist and the defendant himself testified in such a way that the Court of Appeals assumed that seconal is a derivative of barbituric acid and a member of the barbital family of drugs.

The jury found the naturopath guilty of the illegal practice of medicine prohibited by the laws of the

State of Georgia. The Court of Appeals in affirming the conviction, held that it was unlawful in Georgia for barbital and acid diethyl barbituric, among other drugs, to be dispensed except on the prescription of a duly licensed physician. The Court of Appeals further discussed the Act of 1950 defining naturopathy and the practice thereof. That Act, according to the Court of Appeals, excludes from the practice of naturopathy the use of drugs and prohibits those practicing naturopathy in this State from prescribing any drugs, medicines, or other remedies for which a prescription is required.

The Court of Appeals observed the Law Dictionary definition of "drug" to be quite broad—"the general name of substances used in medicine; any substance, vegetable, animal, or mineral, used in the composition or preparation of medicines; any substance used as a medicine."

It is interesting to note that counsel for the State of Georgia and counsel for the naturopath in the trial stipulated that he was a licensed naturopath under the laws of Georgia. For that reason the questionable status of a naturopath practicing as a naturopath today did not come up. In 1956, the General Assembly repealed the Act of 1950 allowing the practice of naturopathy in Georgia and prescribing the limits of that practice. However, the language of the repealing statute is somewhat ambiguous as to its effect upon those licensed to practice naturopathy between 1950 and 1956.*

* This article is based on *Shawver v. The State*, 103 Ga. App. 1, 118 S.E. 2d 202 (1961).

Prepared at the request of the Medical Association of Georgia. Mr. Moore is a member in the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.

1961 CALENDAR OF MEETINGS

State

- Sept. 25-29—Five Days of Internal medicine presented by The Department of Medicine, Emory University School of Medicine. Grady Memorial Hospital Auditorium, Atlanta.
- Sept. 29—Annual meeting of the Georgia Society for crippled Children and Adults. Dinkler Plaza, Atlanta.
- Oct. 2-4—American Medical Association 21st National Congress Occupational Health, Denver, Colo.
- Oct. 6-7—48th Annual Meeting of the Georgia Tuberculosis Association, Georgia Thoracic Society Annual Meeting, Atlanta Cabana Motor Hotel, Atlanta.
- Oct. 12-14—Georgia Academy of General Practice, Annual Session, Jekyll Island.
- Oct. 18-20—Arthritis and Diabetes Seminar. Balmoral Hotel, Miami Beach, Fla.
- May 6-9—Annual Session, Medical Association of Georgia.**

Regional

- Sept. 25-26—Tennessee Valley Medical Assembly, Read House, Chattanooga, Tennessee.
- Oct. 21—Southeastern Allergy Association, Thomas Jefferson Inn, Charlottesville, Va.
- Nov. 6-9—Southern Medical Association, Municipal Auditorium, Dallas, Texas.
- Nov. 16-18—Southern Thoracic Surgical Association, Hotel Peabody, Memphis, Tennessee.
- Dec. 5-7—Southern Surgical Association, Hot Springs, Virginia.
- Mar. 2-5—Southeastern Surgical Congress, Louisville, Ky.
- Mar. 26-28—American College of Surgeons, Sectional Meeting, Hotel Peabody, Memphis, Tenn.
- April 8-11—Tennessee State Medical Association, Peabody Hotel, Memphis, Tenn.
- April 26-28—Alabama, Medical Association of the State of, Tutwiler Hotel, Birmingham, Ala.
- May 12-15—Texas Medical Association, Austin, Tex.

National

- Sept. 23-30—University of Illinois College of Medicine, Annual Otolaryngologic Assembly, Chicago, Ill.
- Sept. 25-28—American Hospital Association, Atlantic City, New Jersey.
- Sept. 25-29—American College of Chest Physicians, Postgraduate Course, Warwick Hotel, Philadelphia, Pennsylvania.
- Sept. 26-29—American Roentgen Ray Society, Deauville Hotel, Miami Beach, Florida.
- Sept. 28-30—American Association for the Surgery of Trauma, Drake Hotel, Chicago, Illinois.
- Sept. 30 - Oct. 3—College of American Pathologists, Seattle, Washington.
- Sept. 30-Oct. 8—American Society of Clinical Pathologists, Olympic Hotel, Seattle, Washington.
- Oct. 1-7—College of American Pathologists, Olympic Hotel, Seattle, Washington.

- Oct. 2-4—American Medical Association 21st National Congress on Occupational Health, Denver, Colo.
- Oct. 2-5—American Academy of Pediatrics, Palmer House, Chicago, Illinois.
- Oct. 2-6—American College of Surgeons, Conrad Hilton Hotel, Chicago, Illinois.
- Oct. 3-4—Congress on Occupational Health, Brown Palace Hotel, Denver, Colo.
- Oct. 8-13—American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago, Illinois.
- Oct. 12-13—Congress of Neurological Surgeons, Summit Hotel, New York City.
- Oct. 15-20—Fourth International Congress of Allergology, the Hotel Commodore, New York, New York.
- Oct. 18-20—Arthritis and Diabetes Seminar, Balmoral Hotel, Miami Beach, Fla.
- Oct. 20-24—34th Annual Meeting, American Heart Association, Miami Beach, Florida.
- Oct. 22-25—American College of Gastroenterology, Hotel Cleveland, Cleveland, Ohio.
- Oct. 22-27—American Society of Anesthesiologists, Inc., Statler Hilton, Los Angeles, California.
- Oct. 23-24—American Cancer Society, Biltmore Hotel, New York City.
- Oct. 23-27—American College of Chest Physicians, Postgraduate Course, Sheraton-Chicago Hotel, Chicago, Illinois.
- Oct. 25-29—American Society of Clinical Hypnosis, St. Louis, Missouri.
- Nov. 2-12—Second Postgraduate Medical Seminar Cruise through the Caribbean. (College of Medicine, University of Florida)
- Nov. 4-5—American Medical Association Conference on Disaster Medical Care, Chicago.
- Nov. 9-11—American Academy for Cerebral Palsy, Chase & Park Plaza Hotels, St. Louis.
- Nov. 13-17—American College of Chest Physicians, Postgraduate Course, Park Sheraton Hotel, New York, New York.
- Nov. 13-17—American Association of Public Health Physicians, Detroit.
- Nov. 16-18—American Psychiatric Association, Hotel Schroeder, Milwaukee, Wis.
- Nov. 25-27—American College of Chest Physicians, Brown-Palace Hotel, Denver, Colorado.
- Nov. 25-Dec. 1—Radiological Society of North America, Inc., Palmer House, Chicago.
- Nov. 27-29—American Society of Hematology, Ambassador Hotel, Los Angeles, California.
- Nov. 27-30—American Medical Association, Clinical Meeting, Denver, Colorado.**
- Dec. 2-7—American Academy of Dermatology and Syphilology, Palmer House, Chicago, Illinois.
- Dec. 4-8—American College of Chest Physicians, Postgraduate Course, Statler-Hilton Hotel, Los Angeles, California.
- Feb. 5-7—American Academy of Allergy, Denver-Hilton Hotel, Denver, Colorado.
- Feb. 7-10—American College of Radiology, Roosevelt Hotel, New York, New York.
- April 2-5—American College of Obstetricians and Gynecologists, Palmer House, Chicago, Illinois.



THE IMPORTANCE OF IDENTIFICATION

James Kenneth McDonald, M.D., *Augusta*

THERE HAS CONTINUED to be elaboration and refinement of Freud's original psychological formulations. The subject of identification is an example of the broadening and elaboration of some of Freud's original ideas.

Identification, as used here, refers to the lengthy process by which a person becomes a unique individual by observing and copying behavior patterns, characteristics, etc. of others. A person may be either aware or unaware that he is identifying with some other person, group, or code. The patterns of behavior that are adopted by a person may be healthy or unhealthy, appropriate or inappropriate. What may be healthy and appropriate for one may not be for another. For instance, quite obviously, feminine mannerisms are not considered appropriate for a male.

The climax in the process of identification occurs during adolescence. This phenomena is readily observable in an adolescent, as he frantically takes on the characteristics of the high school football hero, his older brother, Barry Goldwater, his uncle, Elliot Ness, his father, Alan Shepard, Billy Graham, etc. The healthy solution for this "search for identity" occurs when and if the adolescent finally is able to form an identification primarily with a reasonably healthy father, or mother, or suitable substitute. Obviously, an alcoholic, sexually promiscuous mother would be a poor figure for her daughter to identify with.

Not only must an appropriate person be available, but also the adolescent must be able to identify. This requires that the constitutional makeup

of the individual be adequate, and that the environment has been such that he has been able to "work through" previous stages of his personality development (psychosocial development). It is readily apparent that a child of dull intellect would have difficulties identifying with his biochemist father. It is also apparent that a child who has been consistently rejected and abused by parents who never wanted him, would have personality problems that would preclude the forming of a proper identity.

When a proper identification has not occurred, the clinical picture may be that of almost any of the psychiatric diagnoses. This is undoubtedly influenced by the constitutional and environmental factors that have contributed to the lack of proper identification. If a proper identification does not occur, then one fails to "find himself." He never really develops a firm, acceptable idea of himself as a unique individual. It then occurs that the individual develops a diffuse uncertainty and insecurity about himself as a person. This results in a pervasive feeling of uneasiness (anxiety) or the development of defense against the above-mentioned uncertainty and insecurity. For instance, the person may become very careful and meticulous, afraid to express himself, or he may become a braggart with rigid ideas and patterns of behavior.

The emotional aspects of identification should be differentiated from the intellectual aspects. An emotional identification is largely unconscious and takes place in relation to a "real person" (parent) while an intellectual identification is primarily a conscious one and takes place with a "cultural ideal" of what

a person should be like (the high school football hero, Barry Goldwater, Elliot Ness, Alan Shepard, and Billy Graham, all rolled into one, "identify diffusion"). The individual is, of course, unable to "live up" to this cultural ideal because it does not represent a "real" person, but rather a personification of an ideal and is therefore impossible. This

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

automatically causes a person, without a firm emotional identification with both the positive and negative aspects of a real person, to feel dissatisfied with himself as he really is.

While the lack of a proper identification should not necessarily be considered "the cause" of a mental illness, it can safely be said that the formation of a proper identification is a sine qua non for "mental health."

A.M.A.'S 15TH ANNUAL CLINICAL MEETING

THE 15TH ANNUAL CLINICAL meeting of the American Medical Association will be held Nov. 26-30 at Denver, with a program geared to basic problems of medicine faced by physicians in their practice.

An outstanding scientific program, with emphasis on new research developments, has been planned under the direction of Samuel P. Newman, M.D., Denver, chairman of the AMA's Council on Scientific Assembly.

Some highlights will include sessions and papers on such important areas of medicine as genes and chromosomes, electronics and computers in medicine, space medicine, medical aspects of American habits, new developments in virology, treatment of radiation injuries, new findings in chemotherapy for cancer and latest data in the field of antibodies and antigens, Dr. Newman said.

With more and more nuclear reactors coming into use all over the nation, many practicing physicians soon may begin to face the problem of treating injuries from radiation accidents, the chairman said.

A section of internationally known experts in the treatment of radiation injuries will offer three major papers in this important new area of medical care. Chairman will be Marshall Brucer, M.D., chairman of the medical division, Oak Ridge Institute of Nuclear Studies, Oak Ridge, Tenn.

The radiation experts will discuss such topics as "Potential and Probable Sources of Radiation Accidents," "Diagnosis and Pathology of Radiation Injury" and "Treatment and Prognosis of Radiation Injury." Participants will include researchers from Los Alamos and Oak Ridge, the Office of the Sur-

geon General and the University of Chicago.

The age of advancing physical science also offers new findings to medical science: the use of electronics and computers in medicine. Chairman of this section at the Denver meeting will be A. H. Schwichtenberg, M.D., head of the department of aero-space medicine, Lovelace Foundation for Medical Education and Research, Albuquerque, N.M.

Computer systems for recording medical data to aid the physician in his diagnosis and prognosis will be discussed. Topics will include "The Future of Electronics in Medicine," "Microelectronics and New Concepts of Bioinstrumentation," "A System for Medical Data Recording," and "Biological Computers."

The virus, one of the most complex problems facing the clinician, will be the subject of a series of papers by outstanding specialists. Jonas E. Salk, M.D., Pittsburgh, originator of the killed virus polio vaccine, will give a paper on "Immunization Against Virus Diseases." Other topics will include "the Nature of the Virus and Its Cellular Reaction," "Smallpox Vaccination Complications," "Virus Hepatitis" and "Identification of Viruses."

"We are confident that the 15th annual clinical meeting will offer one of the most interesting and informative programs ever presented at the winter session," Dr. Newman said.

The program is designed to assist the physician in his practice. The latest findings in many areas of medicine will be presented by men who are top specialists in their fields. The meeting will be of great value to the clinician in advancing his knowledge."



heart page

VENTRICULAR TACHYCARDIA

Simone Brocato, M.D., *Columbus*

VENTRICULAR TACHYCARDIA IS AN ECTOPIC rhythm emanating from a focus in the ventricular muscle and is especially ominous since it frequently leads to ventricular fibrillation and death. Some predisposing conditions are myocardial infarction, Digitalis intoxication, thoracic surgery, especially cardiovascular, and procedures such as cardiac catheterization.

Suspicion and astute clinical observation alone will frequently lead to the diagnosis. The ventricular rate of 150 to 200 per minute may at first appear regular, but on careful study, definite slight variations are noted; this is in contrast to the absolutely regular rhythm of paroxysmal auricular tachycardia. The first sound changes in quality and intensity due to altering relations (and volumes) of the auricular and ventricular contractions. Venous pulsations, if visible in the neck, are slower than the apical beat. Carotid sinus pressure produces no change.

The EKG reveals abnormally wide QRS complexes resembling a series of premature ventricular contractions. Interpretation may be quite difficult since the supraventricular rhythms frequently result in aberrant ventricular conduction; but if an occasional P wave is seen bearing no constant relation to the distorted QRS complexes, the diagnosis is almost certain.

The treatment varies with the circumstances. For example, shock may precipitate or perpetuate the ventricular rhythm; in its presence, one should first direct his attention to reversal of this entity which is usually accomplished by the use of vasopressor

agents. If ventricular tachycardia is due to Digitalis intoxication, it should be discontinued and Potassium Chloride given.

The two most reliable medications in other instances are Procaine Amide and Quinidine. When the arrhythmia is occurring in short bursts and the patient is in relatively good condition, oral administration of either may be satisfactory; under grave circumstances the intravenous route will be favored. Orally, Procaine Amide, Gram one, initially, and Grams 0.25 to 0.5 every three to four hours may be given. The same dose and schedule may be used for intramuscular injection. Intravenously, give Procaine Amide, Gram one in 500 cc of five per cent glucose in distilled water over an hour. The strength of the solution can be altered if necessary. As an example, in the presence of left ventricular failure, one would keep the fluid volume to a minimum and Gram one of Procaine Amide in 200 cc. of five per cent glucose in D/W may be used, giving 100 to 200 mg. (20 to 40 cc.) per minute. Stronger solutions in a 10 cc. syringe have been given in the home when the situation warranted it, but this is not recommended since continuous monitoring with the EKG is required for safe intravenous use. Further widening of the QRS complex, moderate hypotension, or convulsions due to treatment are indications for immediately stopping the drug. It is generally conceded that a maximum of two grams may be administered at one attempt unless toxicity or conversion occur before.

If Quinidine is to be used orally, give six grains

HEART PAGE / Continued

every two hours for five doses on the initial day, nine grains every two hours for five doses the next; and on the following day, 12 grains may be used each time, provided there is no toxicity. Extreme anxiety, fever, abdominal distention, or shock will occasionally prevent termination of the abnormal rhythm and repeating the treatment when these conditions are under control frequently results in immediate success. Many who are experienced in the use of Quinidine will increase each successive two hour dose by three grains; thus, the first dose may be six grains, the second, nine, etc., until a maximum of 15 grains has been given at one time. An EKG check is required prior to each increase when

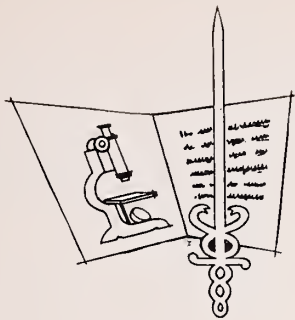
this method is used. It may be well to point out that interpretation is facilitated and much effort is saved by making a long strip of Lead II and V-I rather than a standard twelve-lead trace every two hours.

For I-V administration, 10 cc. of Quinidine Gluconate solution, containing nine grains of Quinidine, dissolved in 50 cc. of five per cent glucose in distilled water, is given at a rate of approximately two cc. per minute until conversion or toxicity occur. The most common side effects are diarrhea, nausea or vomiting, and tinnitus, but these do not warrant cessation of therapy unless they are too incapacitating. Varying changes in the P and T waves, if visible, are usually of no significance, but excessive widening of the QRS complexes (considering that they are already abnormal) and ventricular fibrillation are grave.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Angell, Edward D. M.	Talmadge Mem. Hosp. Augusta, Ga.	Active	Richmond
Fernandez, Bernardo P.	P. O. Box 258 Broxton, Ga.	Active	Coffee
Heath, Tim Ray	701 Elizabeth St. Waycross, Ga.	Active	Ware
Kline, Carl A.	Griffin-Spalding Hosp. Griffin, Ga.	Active	Spalding
Lewis, Esley Earle	303 Smith Street LaGrange, Ga.	Active	Troup
Mangan, Charles G., Jr.	729 Pine Street Macon, Ga.	Active	Bibb
Mitzelfelt, Harold E.	25 Spring St. Ellijay, Ga.	Active	Blue Ridge
Murray, DuBose	207 Edgewood Ave. Atlanta, Ga.	Active	DeKalb
Palmer, Jack R.	131 S. Milledge Ave. Athens, Ga.	Active	C. W. Long
Sanford, Shelton P.	Gilbert Mem. Infirmary Athens, Ga.	Associate	C. W. Long
Standard, Henry C., Jr.	309 Spring St. Washington, Ga.	Active	Wilkes
Walker, Jesse Lee	Nahunta, Ga.	Active	Ware



cancer page

A DOCTOR'S RESPONSIBILITY

John L. Barner, M.D., *Athens*

THERE IS A RESPONSIBILITY each doctor owes his patient and a responsibility which should extend to his fellow practitioner.

Cancer is a condition which if recognized and treated early can usually be controlled or cured. Millions are spent each year in research to find the final answer to this problem. Millions are spent each year to acquaint the public with the early signs and symptoms. Similarly there is an extensive educational program for the medical profession. Probably no medical discussion, seminar, or organized society meeting fails to include some aspect of the cancer patient in its program. This is as it should be—yet today there are doctors who fail to apply what they have learned about cancer, or who may recognize it and fail to properly instruct their patients on the importance of early treatment. An early biopsy which is a simple office procedure, a proctoscopic examination, not always a pleasant procedure, a routine pelvic examination and the ever important Pap smear. Sometimes a delay in investigating the symptoms of the patient who presents themselves with a persistent cough or intestinal upset. Too many times instructing the patient to

use a bland salve or ointment for the chronic sore and never again checking on the outcome. No doctor should ever be too busy to give just a little more time to the patient when cancer is a possible or probable diagnosis.

Nearly every state in cooperation with the National interest of eradicating cancer has its own Aid Program to diagnose or treat the indigent patient. Usually this program is financially overburdened as are many Public Health programs, yet there is always some solution. The State Aid Program for indigent cancer patients is most necessary, but is often abused. It is not intended to give free cancer care to all patients. It can only be applied for by the attending physician who suspects or has diagnosed cancer in his indigent patient. It is the responsibility of this physician, especially to the program, to his fellow practitioner, and to the public in general to adhere to the principles of the Cancer Aid Program. Without each cooperating, there will come the time when funds could be insufficient to take care of the early curable cancer in an indigent patient.

Approved by Professional Education Committee, Georgia Division, ACS.



physician's bookshelf

BOOKS RECEIVED

Kolmer, John A., M.D., **CLINICAL DIAGNOSIS BY LABORATORY EXAMINATIONS**, Appleton-Century-Crofts, Inc., New York, 1961, 543 pp., \$10.00.

Modell, Walter, M.D., **RELIEF OF SYMPTOMS**, The C. V. Mosby Company, St. Louis, 1961, 374 pp., \$11.50.

Cunningham, Robert M., Jr., **HOSPITALS DOCTORS & DOLLARS**, F. W. Dodge Corp., New York, 1961, 275 pp., \$6.95.

Soubrian, Andre, **GOOD-BYE DOCTOR ROCH**, Doubleday & Company, Inc., Garden City, New York, 1961, 331 pp., \$4.50.

Foote, Rowden R., **VARICOSE VEINS**, Williams & Wilkins Co., Baltimore, Md., 1960, 356 pp., \$13.00.

Sodeman, William A., M.D., Editor, **PATHOLOGIC PHYSIOLOGY**, W. B. Saunders Co., Philadelphia, 1961, 1182 pp., \$15.00.

PROCEEDINGS, THIRTEENTH INTERNATIONAL CONGRESS ON OCCUPATIONAL HEALTH, Book Craftsmen Associates, Inc., New York, 1961, 1005 pp.

Coates, John Boyd, Jr., Col., Editor-in-Chief, **PREVENTIVE MEDICINE IN WORLD WAR II, VOLUME V, COMMUNICABLE DISEASES**, U.S. Government Printing Office, Washington, D. C., 1960, 530 pp.

Wolstenholme, G. E. W. and O'Connor, Maeve, **CIBA FOUNDATION SYMPOSIUM THE NATURE OF SLEEP**, Little Brown & Company, Boston, Mass., 1961, 416 pp., \$10.00.

REVIEWS

White, Abraham G., M.D., **CLINICAL DISTURBANCES OF RENAL FUNCTION**, W. B. Saunders Co., Philadelphia, Pa., 1961, 468 pp., \$10.50.

THE AUTHOR IS A WELL-QUALIFIED investigator in renal and electrolyte physiology and is head of a large renal clinic so that he brings to his subject an unusual breadth of knowledge. He is able to present in lucid fashion the fundamentals of abnormal renal physiology which will guide the clinician to a rational diagnostic and

therapeutic approach. His critical judgment greatly enhances the value of the book. The bibliography is carefully sifted and will be helpful to the busy clinician. A brief section on electron microscopy simplifies this field for the beginner in this area. Any internist who covers this text will have a practical and fundamental grasp of renal physiology in health and disease.

A. J. Merrill, M.D.

Trowell, H. C., O.B.E., M.D., **NON-INFECTIVE DISEASE IN AFRICA**, Williams and Wilkins Co., Baltimore, Md., 1960, 481 pp., \$13.00.

THIS BOOK IS QUITE INTERESTING. In a way it is an abbreviated textbook of medicine in which the author allows himself the freedom of discussing predominantly the phases of a disease that are of particular interest to him. There is considerable emphasis on the incidence of different diseases in different parts of Africa and on the possible etiological factors in diseases of unknown cause. He assumes the reader to be familiar with the elementary details of symptomatology, physical findings, and treatment of the diseases common in the Western world and deals with these briefly. However, the predominantly African diseases are covered thoroughly; the sections on treatment of coronary thrombosis and kwashiorkor for example are two lines and two pages, respectively.

The book is successful because of several factors: 1) it is well organized and well written. 2) the author has an excellent grasp of medicine, with a wealth of experience in observing disease and the ability to describe it. His reasoning is sound and his material seems accurate and generally current. 3) his eclectic approach gives the reader a larger percentage of interesting facts.

The main uses of this book will be for reference work in medical libraries and for the physician with more than average curiosity. For such I would recommend it highly.

Grant Wilmer, M.D.

Conwell, H. Earle, M.D. and Reynolds, Fred C., M.D., **KEY AND CONWELL'S MANAGEMENT OF FRACTURES, DISLOCATIONS, AND SPRAINS**, The C. V. Mosby Co., St. Louis, Mo., 1961, 1153 pp., \$27.00.

IN THIS REVISION of "Management of Fractures, Dislocations and Sprains," Dr. Fred C. Reynolds, who was associated with Dr. J. Albert Key, has participated as co-author with Dr. H. Earle Conwell. In the preface they state that their purpose has been to place emphasis on selective injuries and sound methods in their treatment rather than to present an encyclopedia of injuries and their treatment. They keep the treatment of the patient as a whole in the foreground and the discussions of surgical physiology and pathology are particularly good. The book is divided into two parts. The first part is directed to principles and general aspects and the second, takes up specific injuries to the body by regions. Obsolete methods of treatment have been eliminated and discussions on medullary nailing and hip prosthesis, as well as more detailed discussions on deceleration injuries and spinal disc involvement, have been added. The text is easily read and, with the illustrative material, is presented in such a way as to be of great use to the general practitioner, the medical student, the general surgeon, the orthopaedist, and medical personnel in the military forces.

Warner Wood, M.D.

Jopling, W. H., M.D., **THE TREATMENT OF TROPICAL DISEASES**, Williams & Wilkins Co., Baltimore, Md., 1960, 202 pp., \$5.00.

TROPICAL DISEASES are becoming more popular these days as military and political events in Latin America, Africa, and Asia raise the possibility that citizens of temperate climates may find themselves transported to these tropical areas. This pocket sized British volume outlines treatment for a wide assortment of tropical illnesses which such persons might encounter or suffer from themselves. Most of these diseases are infections but also there are included miscellaneous items ranging from snake bite to prickly heat. The author limits himself strictly to a description of treatment; no diagnostic difficulties are dealt with.

The author apparently has had first-hand experience in Africa and should know which diseases to include and which to omit. Nevertheless, a number of diseases, such as tetanus, diphtheria, poliomyelitis, and tuberculosis—which are common problems in some tropical zones at least—are unaccountably omitted. Although these omitted diseases are not peculiar to the tropics, neither are leptospirosis, brucellosis, scurvy, or cirrhosis of the liver, among others, all of which are discussed. The author prescribes for several vague states, such as "tropical ulcer" and "desert sore" which need definition. His concepts of several other diseases are out of date.

The chief objection to this volume is that the physician experienced in tropical medicine will not need so elementary a text; the novice will have difficulty in making the diagnosis necessary to use the book. It is doubtful that the average American physician would find much usefulness here.

Thomas F. Sellers, Jr., M.D.

Marti-Ibanez, Felix, M.D., **A PRELUDE TO MEDICAL HISTORY**, M D Publications, Inc., New York, N. Y., 1961, 253 pp., \$5.75.

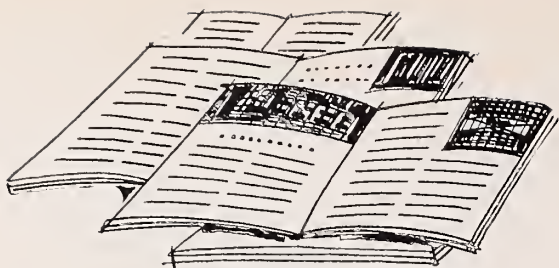
DR. MARTI HAS AGAIN SCORED a resounding literary success with the publication of another in his series of readable medical history texts. In a unique manner, the history of medicine is presented by an author who is as devoted to the spoken word as Toscanini was to the musical note. This all too brief, 200 page history is the recorded lectures of the greatest medical historian since Henry Sigerist. The full panorama of medical history is viewed informally without sacrificing historical accuracy and detail. Dr. Marti delivered his well prepared lectures without notes, had them tape-recorded so that he could subsequently edit the spoken word for publication. This unusual technique has permitted a range of flexibility not otherwise easily accomplished. The delightful descriptions and narrations characteristic of unrehearsed verbal presentation is the outstanding mechanical achievement of this publication.

The student has been spared the monotony of dates. He has presented data in prose akin to that expected of the novel. Frequent departures are made from medical contributions as such to permit the author certain liberties in interpretation of social, religious and economic facets of a civilization appropriate to the age under discussion. "Outstanding among the Pharaohs was Akhenaton, who established a monotheistic cult to the sun disk and had his wife, Nefertete (meaning "the beautiful one has come"), who was also his sister, immortalized in art."

Not since Henry Sigerist has this reviewer found medical history so beautifully and ably presented. Perhaps Marti has for the first time combined the best of Sigerist with the words of a prose genius. In these scant 200 pages almost all of the events, and surely all of the important men parade across the stage from Imhotep to Hans Selye. The author has achieved an enviable position—"it isn't so much what he has to say but the way that he has said it." The historical development of medical science has been presented as part of the main stream of medical history. Techniques have been used to portray the spirit of the various stages of medicine down the ages. "When Mesopotamian and Egyptian medicine is discussed, the student looking down from the top of a ziggurat or a pyramid at the monolithic world of those ancient civilizations is the chosen method of presentation. "Greek medicine is portrayed in the spirit of classical medicine, free and flowing, while the middle ages is presented by reference to a live crowded tapestry. The Renaissance is a boisterous parade through the streets of Padua, and the seventeenth, eighteenth and nineteenth centuries are portrayed as three open windows into the parlor of each. "On the easel of each lecture, he places for the student to study a word canvas depicting the main events in each period in the history of medicine." The twentieth Century is viewed from atop a skyscraper, but in these 20 odd pages which are hardly sufficient to view such a wealth of scientific events, not a single name is mentioned. Movements, ideas and trends, but the names of men are deleted.

Attached to his well indexed volume is a list of Nobel Prize Laureates, and a Selective Medical and Historical Chronology which is a useful reference source.

Peter L. Scardino, M.D.



current clinical concepts

Pyelonephritis

IT HAS BEEN SUGGESTED that the medulla of the kidney is the most susceptible site for bacterial multiplication and is where the earliest histological lesions of pyelonephritis are noted. Experiments have clearly demonstrated that urea in concentrations found in urine produced by normal kidneys during antidiuresis is bactericidal to the most common gram-negative pathogenic bacteria of the urinary tract.

Schlegel, J. U., *Jol. of Urology*, Vol. 86, No. 1, July 1961.

Renal Colic Associated With Chlorothiazide and Hydrochlorothiazide Therapy

RENAL COLIC WITH HEMATURIA and uric acid crystaluria has been observed in two patients following the use of Chlorothiazide and Hydrochlorothiazide for long periods. The exact mechanism for the production of uric acid stones is not known. But it is recommended that patients with edema who receive these forms of diuretic undergo uric acid determinations before and during therapy.

Gelfand, Maxwell L., M.D., *New England Journal of Medicine*, Vol. 265, No. 3, July 20, 1961.

Transfusion Risks are Heightened By Anesthesia

IT IS IMPORTANT that the responsible physician recognize the increased risk of blood transfusions at the time of anesthesia, and should therefore take a second look before subjecting the patient to a one-pint transfusion.

Myers, Robert S., M.D., *Bulletin of the American College of Surgeons*, Vol 46, No. 4, July-August 1961.

Cobalt Radiation for Essential Hematuria

HEMATURIA OF UNEXPLAINED ORIGIN following

complete urological studies has responded to 1500 r of cobalt radiation to the bleeding kidney. When it has been established that the source of the bleeding is a venous calycine channel, the results of this type of radiation therapy has been gratifying in a small series of eight patients.

Mathes, Gordon L., M.D., and Mayer, Raymond F., M.D., *J.A.M.A.*, Vol. 177 No. 1, July 8, 1961.

The Testing of New Drugs and Other Therapeutic Agents

IT WOULD BE WELL FOR every physician clinical or research to familiarize himself with this excellent article. We are reminded of the tragic history of the treatment of disease. Treatment is reported to be specific when because of lack of sufficient time its inherent worthlessness is unrecognized.

Starr, Isaac, M.D., *J.A.M.A.*, Vol. 177, No. 1, July 8, 1961.

Ventricular Septal Defects

VENTRICULAR SEPTAL DEFECT is present in four per cent of healthy, nondistressed, term newborn infants. It was found that the murmur became shorter and less intense, disappearing altogether in 80 per cent by the end of the second year.

Evans, J. R., Rowe, R. D., and Keith, J. D., *Pediatric Herald*, Vol. 11, No. 6, 1961.

Aplastic Crisis in Sickle Cell Anemia

APLASTIC CRISES WERE OBSERVED in 11 children with sickle cell anemia. Seven of the cases occurred in three families implying that infection may play an important etiological role in precipitating such crises.

MacIver, J. E., and Parker-Williams, E. J., *Aplastic Crisis in Sickle Cell Anemia*, *Lancet*, 1:1086, 1961.



the association

DEATHS

FRANCIS SEALS BELCHER, 81, of Monticello, died July 27, 1961. Dr. Belcher graduated from the Atlanta Medical School, which is now Emory University School of Medicine. He practiced in Newton County for one year before moving to Jasper County where he practiced for 60 years.

Dr. Belcher was a member of the Jasper County Board of Education, Chairman of the Jasper Board of Health, clinician for the Jasper Health Center and Jasper Work Camp, a member of Al Shihah Shrine Temple in Macon, Jasper Lodge 50 of Free and Accepted Masons, Monticello Kiwanis Club, the Medical Association of Georgia, the American Medical Association, and the Monticello Methodist Church.

His survivors include his wife, Rena Maude Starr Belcher; one son Jack Belcher of Jacksonville, Fla.; one daughter, Mrs. A. T. Young of Laurel, Md., and five grandchildren.

FREDERICK W. COOPER, JR., 45, Associate Professor of surgery at Emory University died August 1, 1961 in his home in Dunwoody.

Dr. Cooper was a graduate of Georgia Military Academy and Emory University School of Medicine. A specialist in vascular surgery, he was associated with Emory University since 1941. He was a trustee at Georgia Military Academy, civilian consultant to the Third Army physician at Fort McPherson, Fellow of the American College of Surgeons, member of the American Medical Association, the Medical Association of Georgia, the Society for Vascular Surgery, and the American Surgical Association.

Survivors include his parents, Mr. and Mrs. Frederick W. Cooper, Sr., of College Park, a sister, Mrs. James F. Ward, Jr., East Point, and a grandmother, Mrs. W. C. McClain of Nelson.

JOHN BRUNSON CROSS, 61, of Atlanta, head of Emory University Hospital's Obstetrics and Gynecology Department, died July 23, 1961.

Dr. Cross graduated from Mississippi College, attended the University of Mississippi and received his M.D. degree from Northwestern University. During World War II, he served as a lieutenant Colonel with the 43rd Army General Hospital in the European and African theatres as a member of the Emory University Hospital unit. Dr. Cross was Past President of the Atlanta and the South Atlantic Obstetrics and Gynecology Societies, a member of the American Medical

Association, the Medical Association of Georgia, the Atlanta Clinical Society, the Georgia Obstetrics and Gynecology Society, a Fellow of the American College of Surgeons and the American College of Obstetrics and Gynecology, and a diplomate of the American Board of Obstetrics and Gynecology. He was a member of the Second Ponce de Leon Baptist Church and the Masons.

He is survived by his wife, Francis Tilling Cross, a son, John D. Cross, Jr., of Atlanta; two sisters, Mrs. E. G. Catlett, Meridian, Miss., and Mrs. C. A. Morris, Tylertown, Miss.; and two brothers, Claude B. and William A. Cross, both of Boston, Mass.

BUNA COLUMBUS POWELL, 92, of Villa Rica, former President of the Medical Association of Georgia, died July 25, 1961.

Dr. Powell was a surgeon, and pharmacist in Villa Rica since 1890. Dr. Powell graduated from the Chattanooga Medical College. He was a member of the American Medical Association, the Medical Association of Georgia, a charter member of the Villa Rica Civitans and a steward in the Villa Rica Methodist Church.

His survivors include a son, Jack C. Powell; three daughters, Mrs. W. C. Dumas, Mrs. A. L. Crittenden and Mrs. R. C. Lovett.

GEORGE BARKER SMITH, 75, of Rome, died August 7, 1961 in his home. Dr. Smith had been associated with the Harbin Clinic in Rome for 48 years before his retirement in 1959. He attended the University of Georgia and received his medical degree from the Medical Department of the University in 1908. His internship was at Lamar Hospital in Houston County where he practiced medicine for a year.

Dr. Smith was Chairman of the Board of Directors of the National City Bank and Chairman of the Board and Medical Director of State Mutual Insurance Company. He was one of the organizers of the Rome Rotary Club, founder and Past President of the Northwest Georgia Council, Boy Scouts of America, a member of the original Board of Trustees of Darlington Schools, a Commander of Shanklin-Attaway Post 5, American Legion, Past President of the Floyd County Medical Society and the Seventh District Medical Society, member of the Medical Association of Georgia, the American Academy of Ophthalmology and Otolaryngology, and certified by the American Board of Ophthalmology.

Survivors include his wife, Patti Willingham Smith; a daughter, Mrs. Thomas A. McGoldrick of Savannah;

three sons, George B. Smith, Jr., Dr. Stephen David Smith, and Dr. Lucius Stone Smith, all of Rome; two brothers, Melvin A. Smith of Orlando, Fla., and Armin Smith of Tampa, Fla.; one sister, Mrs. Proctor Page of Burlington, Va.; 16 grandchildren and one great-grandson.

MADISON HINES ROBERTS, 65, Director of the Eggleston Hospital for Children for 30 years, died July 29, 1961 in his home in Atlanta.

Dr. Roberts was associated with Emory University as Chairman of the Department of Pediatrics since 1921. He was a graduate of the University of Georgia and completed his internship at St. Christopher's Hospital for Children in Philadelphia, Boston Children's Hospital and Boston Infant's Hospital. During World War I he served in the Navy as a medical officer.

Dr. Roberts received the L. C. Fisher Award in research in 1925 and 1927 and the Crawford W. Long Award for research in 1927. He was the Past President of the Georgia Pediatric Society, former Chairman of the Pediatric Section of the Southern Medical Association, and a former Board member of the American Board of Pediatrics. He was also a member of the American Medical Association, the Medical Association of Georgia, and the All Saints Episcopal Church.

He is survived by his wife, Delia Paige Johnston Roberts, two sisters, Mrs. Frances Roberts Bruce of Atlanta, and Mrs. William J. Cranston of Augusta.

SOCIETIES

Dr. George W. Smith, Professor of Surgery and Neuro Surgery at the Medical College of Georgia, spoke to members of the BALDWIN COUNTY MEDICAL SOCIETY on injuries to the cervical spine, at their June meeting.

The BIBB COUNTY MEDICAL SOCIETY has appealed to the people of Macon to build an addition to the present Macon Hospital. Recently the Society held a breakfast to present their member views on the King Bill to business men in Macon.

Members of the DOUGHERTY COUNTY MEDICAL SOCIETY and their wives entertained the intern house staff of the Phobe Putney Memorial Hospital at a reception recently.

Members of the LAURENS COUNTY MEDICAL SOCIETY have urged the people of their county to write their congressman and state opposition to the King Bill and confidence in the Kerr-Mills law.

The PEACH BELT MEDICAL SOCIETY and the Peach and Houston County Heart Councils co-sponsored a Stroke Rehabilitation Clinic at the Army Reserve Training Center at Fort Valley during July.

Members of the STEPHENS COUNTY MEDICAL SOCIETY examined the Stephens County High School football players free of charge before training began.

Dr. Arthur M. Knight presented the scientific program

for the WARE COUNTY MEDICAL SOCIETY in August. The topic was "External Cardiac Resuscitation."

PERSONALS

First District

LOUIS H. GRIFFIN of Claxton was recently installed as President of the Alumni of the Medical College of Georgia at the annual banquet held in Atlanta.

JOHN E. PORTER has been named the new city physician for Savannah. He replaced JOHN F. HOWKINS, who has retired.

SAM YOUNGBLOOD, JR. has opened an office in Rincon.

E. THOMAS UPSON of Savannah has moved to Atlanta to accept an administrative post with the Veterans Administration.

Second District

JACK ROLES PALMER of Camilla has opened an office at 131 South Milledge Avenue in Athens.

J. G. CROVATT, Camilla, has closed his office in Camilla and has taken a position with the Veterans Hospital in Dublin.

Third District

No news submitted.

Fourth District

CECIL P. MAYOR has been appointed the new Troup County physician. He succeeds H. H. HAMMETT.

U. H. HARTE of Newnan was recently elected an Active Fellow of the American Academy of Psychosomatic Medicine.

Fifth District

CHRIS J. McLOUGHLIN of Atlanta was elected to the Council of the American Diabetes Association at the meeting in New York prior to the A.M.A., annual session.

BRUCE LOGUE of Atlanta was recently a guest lecturer at the Mayo Clinic.

JOHN R. LEWIS, JR., Atlanta, has been elected president of the Atlanta Writers' Club.

JOHN H. VENABLE of Atlanta was the guest of Twiggs County in August when he dedicated the new \$45,000 County Health Center.

The ATLANTA PSYCHIATRIC CLINIC invited Dr. J. B. Rhine, Duke University, to speak at their 3rd Annual Lectureship Program. He spoke on "Parapsychology And Man's Search For Understanding."

Sixth District

BURCH J. ROBERTS of Atlanta has been appointed as regional medical director of the Central Region, Georgia Department of Health and has moved to Macon to assume his duties.

LEWIS H. PARRISH who has been practicing medicine in Albany, has returned to his home town of Wrens and opened an office.

CHARLES G. MAGNAN, JR. has moved to Macon to

practice. He recently finished his residency in plastic surgery in Kansas City General Hospital.

CHARLES ROBERT IRELAND of Macon spoke in July to the Tifton Rotary Club. The topic of his speech was "The Bright Side of Heart Disease."

Seventh District

DONALD C. STECKER formerly of Dalton has moved to Lakeland and has joined the staff of the Louis Smith Memorial Hospital.

W. P. SMITH of Bowden celebrated his 95th birthday in July.

WILLIAM P, HARBIN, JR. has been elected president of Rotary in Rome for the coming year.

Eighth District

GABE WILLIS was honored in August when his hometown Ocilla in Irwin County saluted him for his 50 years of practice.

VILDA SHUMAN of Waycross has been reappointed to the post of State Advisor on Women's Activities of the National Foundation in the Eastern Georgia Area.

J. LEE WALKER of Wise, Virginia opened offices in Nahunta at the new Brantley County Medical Center in July.

EMANUEL A. DANNEMAN of Waycross spoke to the Second Annual Summer Symposium of the Blue Ridge Chapter of General Practice in Roanoke, Virginia and was guest lecturer at the Veterans Administration Hospital in Salisbury, North Carolina during the month of July.

Ninth District

DANIEL CLAUDE KELLEY was honored recently by his home town newspaper, the "Lawrenceville News-Herald," as the Citizen of the Week.

The TOCCOA CLINIC MEDICAL ASSOCIATES sponsored another program in Continuing Postgraduate Education when Dr. Frank Epsey, a neurosurgeon from Greenville, S. C. spoke on brain tumors.

RICHARD TORPIN of Augusta spoke to the Cornelia Kiwanis Club in August.

Tenth District

No News Submitted

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE JULY MEETING of the Medical Association of Georgia Executive Committee of Council was called to order by President and Chairman Fred H. Simonton at 3:05 P.M. at Dr. Simonton's farm, Centralhatchee, Georgia.

The members of the Committee present were: Fred H. Simonton, Chickamauga, President and Chairman; Thomas W. Goodwin, Augusta, President-Elect; George H. Alexander, Forsyth, Chairman of Council; Milford B. Hatcher, Macon, Immediate Past President; John T. Mauldin, Atlanta, Secretary; J. G. McDaniel, Atlanta, Chairman of Finance; Linton H. Bishop, Jr., Atlanta, First Vice President; and C. Raymond Arp, Atlanta, Treasurer. Also present were Mr. Richard Nelson, AMA Field Representative; Mr. Milton D. Krueger, Executive Secretary; Mr. James M. Moffet, Assistant Executive Secretary; and Mrs. Catherine Wooten, Executive Assistant.

The invocation was given by Dr. Alexander.

The minutes of the June 10-11 Council meeting were reviewed and the June 9-10 Executive Committee meeting minutes were read by Mr. Krueger. On motion duly made and seconded the minutes were approved as read.

REPORT OF TREASURER—Dr. Arp gave the monthly budget report. The operating expenses of the *Journal* were discussed. It was recommended that the Editor of the *Journal* attend the next Executive Committee meeting and discuss these expenses. It was emphasized that the present quality of the *Journal* must be maintained. On motion (McDaniel-Hatcher) it was voted to approve the Treasurer's report.

BOARD AND COMMITTEE APPOINTMENTS—Mr. Krueger read letters from various members who have declined, for one reason or the other, to serve on the Boards and Sub-Committees. It was recommended that these be referred to the Chairman of the Board under whose jurisdiction the Sub-Committee falls, for suggested appointments subject to approval of Executive Committee.

Those referred were as follows:

(a) Rehabilitation and Crippled Children Sub-Committee: A letter from Jack Hughston, Columbus, was read. On motion duly made and seconded it was voted to refer this to the Chairman of the Board of Governmental Medical Services.

(b) Maternal and Infant Welfare Sub-Committee: On motion duly made and seconded it was voted to refer Eugene L. Griffin's selection of committee members to the Chairman of the Board of Governmental Medical Services.

(c) Medical Civil Preparedness Sub-Committee: Edgar Dunstan, Atlanta, and MAG House of Delegates requested change of name to Disaster Medical Care Sub-Committee, and appointment of new members. On motion duly made and seconded it was voted to refer this to the Board of Governmental Medical Services.

(d) Woman's Auxiliary Advisory Sub-Committee: Dr. Hatcher felt he should not be a member of this Sub-Committee and that President-Elect Thomas W. Goodwin should have been chosen in his stead. On motion duly made and seconded it was voted to make this change and to appoint the President-Elect to this Sub-Committee now and in the future.

(e) Sub-Committee on Rural Health: On motion duly made and seconded it was voted to refer the resignation letter of Charles E. McArthur, Cordele, to the Chairman of the Board of Occupational Health.

(f) Sub-Committee on Industrial Health: On motion duly made and seconded it was voted to refer the resignation of Henry S. Jennings, Gainesville, to the Chairman of the Board of Occupational Health.

(g) Sub-Committee on School Child Health: After considering a recommended change of committee membership from Grady E. Black, Griffin, who declined, and on motion duly made and seconded, it was voted to appoint William H. Bonner, Athens, as Chairman of the above Sub-Committee and a member of the Board of Governmental Medical Services; also to appoint John Bowen, Sandy Springs, a member of the Sub-Committee.

VOCATIONAL EDUCATION LIAISON—After discussion it was recommended that this be deferred until Dr. Hatcher discusses it with Mrs. Fannie Mae Walker, State Supervisor, Practical Nurse Education, State Department of Education.

REPORT OF HOSPITAL ADVISORY COMMITTEE MEETING—Secretary Mauldin read Rafe Banks', Gainesville, report on the meeting. There was general discussion following this and it was received for information.

PHYSICAL THERAPY ASSOCIATION LIAISON—After discussion it was recommended that MAG write the Physical Association that this item was tabled pending further investigation.

PODIATRY LIAISON CLARIFICATION—Mr. Krueger requested clarification concerning liaison with the Georgia Podiatry Association in regard to the Blue Shield Act and inclusion of podiatrists' services therein. Mr. Krueger read the March 25, 1961 Council minutes, at which time this subject was brought up. The action of Council was recorded per the minutes as follows: "After general discussion and on motion it was voted that the Chairman appoint a committee to study this matter with the MAG attorneys and report to Council." Mr. Krueger then read the Executive Committee minutes of April 22, 1961 which record this item as being deferred.

Mr. Krueger then further read the MAG Council meeting minutes of May 6, 1961 as follows: "Chairman McDaniel, at the request of Council, appointed three physicians to assist the Georgia Podiatry Association in changing the Blue Shield Act. . ."

After discussion of these minutes, it was requested that they be referred to Council at their September meeting for correction and clarification, as the Executive Committee felt the three physicians appointed by Dr. McDaniel at the May 6 Council meeting were to study the matter and report back to Council, and they were not, in fact, to act further on the matter until such report was received by Council.

GENERAL CORRESPONDENCE—Secretary Mauldin discussed the following for Executive Committee action:

(1) National League for Nursing Program Publicity: This correspondence was read requesting endorsement of the program. It was recommended that this be received for information only and that no reply would be necessary.

(2) Bar Association Convention Participation: On motion (McDaniel-Hatcher) it was voted that representatives' names be sent to the Bar Association and notify these physicians about attendance at their own expense.

(3) AMA Medical Quackery Meeting Participation: It was recommended that the Fulton County Medical Society representative also represent MAG and give Executive Committee a report. On motion duly made and seconded it was so voted.

(4) A. H. Robins Civic Award Request: On motion (Goodwin-Alexander) it was voted to reject this request and to write the company to this effect.

(5) Georgia P.T.A.: On motion (Mauldin-Hatcher) it was voted that a letter be written by the Secretary that the MAG name could not be used as an endorsing agency for publicity purposes, but that MAG would make every effort to get County Medical Society assistance, if notified of various projects.

Secretary Mauldin then reported on the following items for information:

(1) Hospital-Medical Council Meeting July 9, 1961 Data: Received for information.

2) Nursing Home Accreditation: On motion duly made and seconded it was voted to ask Drs. Hatcher and Mauldin to appoint a liaison member and to notify the Nursing Home Association.

(3) Meriwether-Harris County Society Problem: Report received for information.

(4) Nahunta Sears Roebuck Dedication: Report received for information.

(5) Interprofessional Council Veterinary Membership Reply: Report received for information.

(6) C. W. Long Memorial Status: A letter from the Georgia Historical Commission was read about the reopening of the C. W. Long Memorial Museum. It was recommended that a letter be written to Mrs. Jewett commending the Commission on their action.

HEADQUARTERS OFFICE REPORT—Mr. Krueger discussed the following:

(a) 1961 MAG House of Delegates Action (Resolution 3): It was recommended that this be referred to the Board of Insurance and Economics with instructions to report back to Executive Committee.

(b) 1961 AMA Institute: On motion (Hatcher-McDaniel) it was voted not to send a representative this year.

(c) Headquarters Employees' Resignations: Mrs. Jean Buice, of Medicare Department, and Miss Lynne Rachelson, general secretary, resigned on July 21, 1961. Secretary Mauldin and Mr. Krueger were instructed to seek replacements for the positions.

KING BILL ACTIVITY—Mr. Moffett gave a status report.

AMA ANNUAL MEETING REPORT—Drs. McDaniel, Simon, Mauldin, et al gave the Executive Committee some highlights of the AMA June meeting in New York.

UNFINISHED BUSINESS

(1) Letter of Congratulations: It was recommended that the Secretary write Eustace A. Allen a letter of congratulations about his election as Vice President of the AMA.

NEW BUSINESS

(a) Date and site of August Executive Committee meeting: August 27, 1961, at MAG Headquarters, Atlanta.

(b) Date and Site of September Council meeting: September 16-17, 1961, at King and Prince Hotel, St. Simons Island, Georgia.

There being no further business the meeting was adjourned.

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of the

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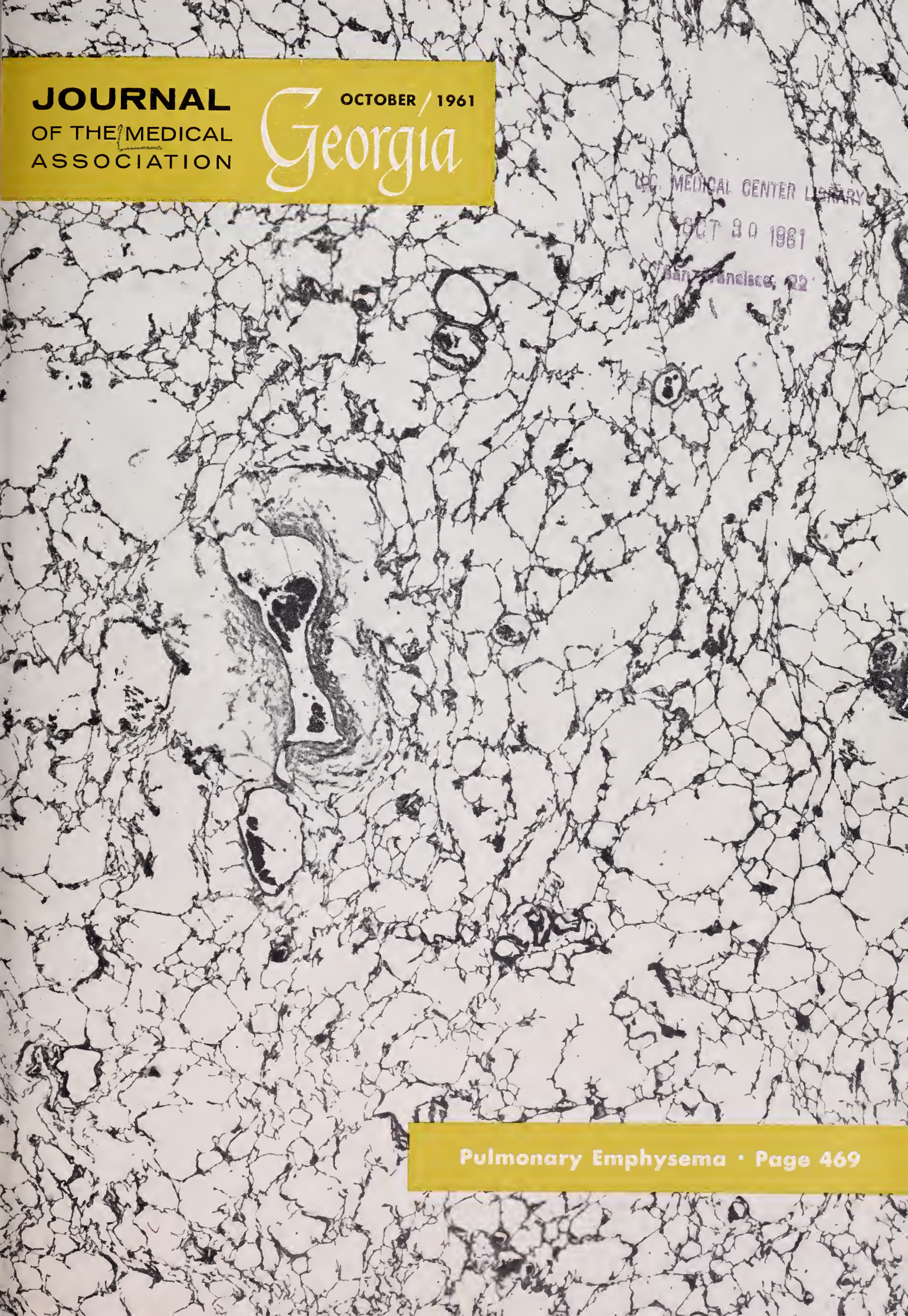
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PATHOGENESIS AND TREATMENT OF PULMONARY EMPHYSEMA

Substantial increase in the incidence of emphysema in the United States and other highly industrialized countries has been noted in recent years.

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THERE HAS BEEN A PRONOUNCED INCREASE in the reported mortality rate of pulmonary emphysema during the past decade. This is in line with an estimated incidence of this disease of five to ten per cent of persons over 40 years of age.

In current texts, the subject under discussion is designated by various names, some of them bad misnomers, such as obstructive emphysema, hyperthrophic emphysema, pulmonary hypertrophy, pulmonary dilatation, pneumonectasis, progressive obstructive pulmonary atrophy, chronic large lung, dystrophic emphysema, diffuse vesicular emphysema, genuine and idiopathic emphysema.

For years, I have been advocating the term pseudohypertrophic emphysema so as to do away with the fallacy of imputed hypertrophy of specific structural elements of the lung and still indicating its increased volume.

I presume confusion relative to pathogenesis, diagnosis and treatment of this disease arises from lack of clear understanding of its basic characteristics. With this in mind, it is essential to point out

that, contrary to generally accepted views, pulmonary emphysema is not a single disease, rather it is a disease syndrome. It is the composite manifestation of the following fundamental pathological changes. 1. Pronounced loss of elasticity of the lung in consequence of bilateral, widespread destruction of its elastic components, which may be referred to as elastoclasia or pathologic elastosis. 2. Corresponding, simultaneous destructive changes in the angio-alveolar membrane. This is associated with loss of perialveolar capillaries with consequent decrease in the oxygen-carbon dioxide exchange. Concomitant dilatation of the terminal and respiratory bronchioles is likely to be present. 3. Persistent partial lower-airway obstruction. 4. Break-down of the "visceral lung function" as conceived by Rappaport (1954). This term means decrease in the amount, consistency and biochemical competence of the alveolar lining membrane which is the actual diffusion surface of pulmonary gas exchange. This membrane constitutes a delicate, semi-fluid, jelly-like film. It is constantly secreted by special types of cells at the junctions of alveoli and bronchioles. The control of their function is enzy-

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matic or hormonal and it is separate and independent of pulmonary ventilation. Decrease or cessation of function of the alveolar lining membrane is referred to as visceral dysfunction of the lung.

With disappearance of alveolar septa, air spaces of various sizes develop which are conventionally called bullae within the substance of the lung and subpleural blebs when they are on its surface. Interestingly, it has been noted on thoracoscopic examination that these blebs expand on forced expiration.

The following distinct clinical entities are excluded from discussion: 1. Focal Emphysema; 2. Localized Emphysema; 3. Localized Hypertrophic Emphysema (Congenital Lobar Emphysema, Regional Obstructive Emphysema); 4. Senile Emphysema; 5. Congenital Cystic Disease of the Lung; 6. Bronchiolar Emphysema of the Lung; 7. Kountz—Alexander type of emphysema.

Etiology

It is permissible to assume congenital constitutional inferiority of the specific and supportive structures of the lung (hypoplasia or disturbed post-natal development) as a possible factor which predisposes to emphysema. Increased incidence of emphysema from this source, however, has not been proved.

There are three plausible etiologic factors which are considered significant in current medical thinking. The first of these is increased intra-alveolar pressure brought about by check-valve mechanism in the respective bronchi and bronchioles. Laennec (1819) stated that the stretching and tearing effect of air trapped distal to partial occlusion of bronchioles or small bronchi was brought about by accumulation of inflammatory exudate. Brown-Sequard (1885) attributed this check-valve type of bronchial occlusion to bronchospasm. Histological examination actually reveals hypertrophy of peribronchial and peribronchiolar smooth muscles as the result of bronchospasm. I am of the opinion that the latter should not be lightly dismissed as a possible etiologic factor. In support of such casual connection, I want to quote Hajos and Hajos (1959) who found emphysema in 74.8 per cent of 1,000 patients with bronchial asthma. In addition to its classical example in allergic bronchial asthma, bronchospasm may originate from other causes. These include parenchymal, interstitial and bronchial infections, pulmonary congestion in heart failure, reflex irritation of the vagus nerve at extra-

pulmonary sites, hyperpotassemia induced by vigorous diuresis in patients with heart failure, excessive production of mucus by medicinal agents, excessive tobacco smoking, protracted severe coughing, psychosomatic reaction.

It is well to point out at this time that it is rarely possible to produce emphysema experimentally by stretching the alveoli by overinflation.

The second thought of equal bearing postulates that inflammatory changes of infectious or allergic origin are capable of undermining the anatomic integrity of lung structures. Consequently, normal or greater than normal pathologic physical stress and strain may cause irreparable tissue loss. McLean (1959) was able to demonstrate such damage to bronchioles in pulmonary infection, with their consequent collapse and occlusion during expiration. Williams (1958) maintains that in patients with allergic bronchial asthma, emphysema occurs only as a result of repeated episodes of infective bronchiolitis. Cloetta (1911 and 1913) first expressed the view that obliterative changes in blood vessels of the lung contributed to degenerative alterations in the elastic fibers and alveoli. Rappaport and Mayer (1960) say that damage to the delicate alveolar lining interface may be brought about by infections, allergic inflammation, toxic, physical and chemical agents which reach these structures either by inhalation or by the blood stream. Crenshaw and his associates (1960) first succeeded in demonstrating that chemical obstruction of nutrient vessels of the lung resulted in degenerative changes in the alveolar walls and elastic fibers, with consequent development of typical emphysema.

The third adverse factor in the pathogenesis of emphysema is strenuous coughing. I have emphasized in previous writings (1954, 1956, 1959) that sudden rise in intrapulmonary air pressure (pulmonary pneumatic hypertension) should be looked upon as a potent aerodynamic trauma. McCann and his co-workers (1949) found that during strenuous coughing the pressure within the lung rose to as high as 200 mm. of mercury over and above atmospheric pressure. It is of interest to mention in this connection that this traumatizing effect is cumulative, that is, with each consecutive coughing spell an increment of positive pressure is added to that of the air entrapped in the corresponding alveoli. Moreover, at the termination of the compressive phase of cough, when there is a precipitous drop in the intrapulmonary pressure, evacuation of air is slower from alveoli attached to spastic or otherwise partially occluded bronchi than from alveoli connected to bronchi of normal lumen. This regional expiratory lag exerts significant dis-

tending influence upon the alveoli implicated.

If these items are accepted as likely causes of emphysema, one can readily appreciate the high incidence of this condition secondary to a number of pulmonary diseases. Among the latter, prominent role should be attributed to allergic bronchial asthma, chronic bronchitis, diffuse pulmonary fibrosis, including pneumoconiosis, and nonallergic bronchospasm. In view of the high incidence of these diseases, it should not be surprising, therefore, that emphysema is one of the most common chronic afflictions of the lung.

Heavy smoking is always associated with chronic bronchitis. Because of this, the likely development of emphysema should be considered one of the serious sequels of excessive smoking. The latter also entails pathologic changes due to nicotine, namely precapillary vasoconstriction, local tissue acidosis and bronchospasm. Lowell and his colleagues (1956), Phillips and his associates (1954) maintain that heavy smoking, especially cigarette smoking, is a common, perhaps specific cause of emphysema. Similar view was expressed by Franklin and his associates (1958) and by Flick and Paton (1959). Interestingly, Eich and his collaborators (1957) observed that one cigarette caused increased resistance to air flow in patients with emphysema, thus increasing respiratory disability. No such effect was observed in persons without emphysema. Whitfield and his associates (1951) say that smoking decreases chest expansion, produces diminished vital capacity of the lung, increase in the residual air and an increase in the latter in relation to the total lung volume. Bickerman and Barach (1945) deny these claims.

Substantial increase in the incidence of emphysema in the United States and other highly industrialized countries during recent years may be partly attributable to exposure to noxious fumes, gases and dusts within industrial plants, mines, smelters or to atmospheric pollutants, such as dusts, soot, smoke, fumes and gases dumped into the air from industrial establishments, public utility facilities, households or from motor vehicles (gasoline and diesel engines), from liquid fuel storage tanks, coke plants and gas works. Experimental and clinical observations offer ample proof that incomplete combustion products of solid (coal) and liquid fuel are common cause of chronic bronchitis. These include ozone, oxides of nitrogen, nitro-olefins, sulfur dioxide, sulfuric acid and others.

Wood and his colleagues (1959) suggested that some cases of emphysema in adults might represent formes frustes of mucoviscidosis (fibrocystic disease of the pancreas). They found that concentration of sodium chloride in the sweat was abnormally high

in about 20 per cent of patients with "chronic obstructive emphysema".

Of course, aging of the population does influence the incidence of emphysema. In the United States about ten per cent of the population are 65 years of age or older. Resistance, defense and repair capacity are less competent in senescence than in younger age groups. This implies an increased incidence of chronic bronchitis with all of its adverse sequels, including emphysema. Specifically, the tensile strength and the resilience of the tissues are less in the aged than in young individuals. Accordingly, the alveoli become flabby like the skin. Dilation of the alveoli is the result of atrophic changes in the alveolar septa. Simultaneously, some of the elasticity of the lung tissue is lost too (senile elastosis). In the aged, there is functional limitation of the diaphragm. Its central tendon becomes more fibrous and constitutes a larger part of this muscle than in individuals of younger age. The diaphragm as a whole becomes flabby as other striated muscles. Added functional impairment results from rigidity of its connective tissue elements due to decreased turgescence of their collagen. Too, there is lessening of the efficacy of neural control. The decreased cholinesterase content of the blood serum favors bronchospasm.

In a great many instances, emphysema detected in aged persons is traceable to protracted lung infections and allergic bronchial asthma in childhood. Damaging lung changes in the young are likely to be counterbalanced by the functional competence of intact pulmonary structures. The latter, however, in senescence undergoes involutional degenerative changes. Also, they may be affected by intercurrent lung infections or by bouts of severe coughing. Consequently, subjective and objective manifestations of emphysema become evident.

Clinical Manifestations and Adverse Sequels

In emphysema the work of breathing is increased because of the overstretched state of the lung, functional insufficiency of the alveolar surface lining, increased resistance to air flow and low position and functional failure of the diaphragm. A significant factor in the causation of dyspnea is the decreased efficiency and greater oxygen demand of the respiratory muscles.

The tidal air is normal or slightly reduced but its physiologically uneven distribution becomes exaggerated. Inflow of air is easier into arcas of emphysema than into normal alveoli.

Dilatation of the alveolar ducts obviates their usual jet-like effect upon inflowing air. Consequently, inadequate alveolar ventilation and insufficient

alveolar gas mixing result. Distended emphysematous air spaces may prevent inspiratory expansion of normal alveoli or act as an "air-clamp" or "pneumatic vise" in blocking patent bronchioles. The latter are disproportionately narrow as compared to their attached, distended alveoli.

The inspiratory reserve volume is reduced. The functional residual air is from two to three times that of normal. The maximum breathing capacity is reduced. Vital capacity of the lung is lowered by 20 to 80 per cent although it is known that in some patients it may remain normal. Due to airway obstruction, there is pronounced and persistent reduction of maximum mid-expiratory air flow rate. There is disordered relationship between pulmonary ventilation and alveolar perfusion. The timed respirogram of Gaensler (1951) registers values far below normal. The nitrogen wash-out time is prolonged.

Oxygen saturation of the blood is below normal. It may be as low as 60 per cent. In addition to its vasoconstrictor effect, hypoxia may result in increased cough irritability and tendency to bronchospasm, also, it may cause myalgia of the diaphragm and the intercostal muscles. Hypoxia impairs permeability of cells, and thus it interferes with oxygen uptake and with the uptake of nutrients.

Carbon dioxide content of the alveoli is increased to seven-eight per cent (50-60 mm. of Hg.). Hypercapnia becomes more pronounced with progression of the disease. It is well to remember that patients with hypercapnia are very sensitive to narcotics.

Donald and Christie noted (1949) that following the inhalation of four per cent carbon dioxide for a period of five minutes the respiratory response was impaired.

Return flow of venous blood from the greater circulation to the right auricle is decreased. Venous pressure is increased. The large cervical veins are distended. Diminished inspiratory expansion of the lung fails to dilate the pulmonary vascular bed so as to establish a gradient which normally facilitates blood flow from the right ventricle to the lung. There is shunting of non-oxygenated blood from abnormally distended "slow" alveoli.

Pulmonary artery pressure is elevated. Experimental studies show that both hypoxia and hypercapnia cause pulmonary vasoconstriction. Other factors which play a role in bringing about pulmonary hypertension include polycythemia, hypervolemia and increased right ventricular output. Of course, destruction of alveolar capillaries as well as their compression, together with small branches of the pulmonary artery, by distended air spaces

represent a barrier in the way of free pulmonary circulation.

In the roentgenogram, lung fields appear devoid of normal, delicate net-like linear pattern. Not always is there parallelism between X-ray appearance of the emphysematous lung and increase in the right ventricular and pulmonary artery pressures. One of the possible explanations of this discrepancy may lie in variability of bronchospasm and its effect on pulmonary circulation.

Most Common Cause of Cor Pulmonale

Emphysema is the most common cause of cor pulmonale. From 70 to 100 per cent of patients with emphysema have been reported with this complication. Harvey and his associates (1951) emphasized that emphysema may cause reversible cor pulmonale. Inasmuch as an acute respiratory infection may bring about clinical evidence of cor pulmonale, the latter may not be detectable in the absence of infection. Heart failure in cor pulmonale is associated with right ventricular dilatation, venous hypertension, greatly increased blood volume, congestion and edema; cardiac output may or may not be increased. Heart failure is aggravated by severe respiratory infection. Alertness to the adverse, provocative influence of cough, infection and bronchospasm is important from the standpoint of prevention and management.

In pseudohypertrophic emphysema the diaphragm occupies a low position and it is hypokinetic. Because of diaphragmatic dysfunction, venous return to the heart is decreased and the efficacy of cough is greatly handicapped. Moreover, tussive insufficiency is worsened by bronchospasm, derangement of bronchial peristalsis, inspissation of bronchial secretions by hypoxia and by collapse of some of the lower air passages during strenuous cough. Also, it is well to keep in mind that there is an increased tendency to cough syncope and to other cough hazards.

There is an increase in the bicarbonate reserve in the blood. Plasma chlorides are decreased.

Hypoxic stimulation of the bone marrow results in polycythemia with increase in the size of the erythrocytes. Absence of polycythemia in patients with severe emphysema is suggestive of refractoriness of the bone marrow to stimulation by erythropoietin.

Dyspnea, the most common symptom of emphysema may be absent during rest. On the other hand, there are instances in which oxygen is necessary to keep the patient comfortable even in bed. Dyspnea is worsened by superimposed bronchial infection and by bronchospasm. A great many of these patients are living in a state of chronic respira-

tory fatigue, in a hypoxic and hypercapnic internal milieu.

Cerebral venous stagnation and hypoxia are likely to cause mental sluggishness, somnolence, headache, giddiness, weakness, diminished hearing, tremor, loss of appetite, nausea and occasionally, episodes of disorientation and hallucination.

Geschickter and Popovici (1953) attribute concomitant hypertension to passive renal congestion and consequent vasospasm. Stuart-Harris and his colleagues (1956) published data which showed that in patients with emphysema and pulmonary heart failure there were greatly diminished renal plasma flow and moderately reduced glomerular filtration rate. These changes were found reversible with recovery from heart failure.

So-called morning asthma is one of the well known manifestations of emphysema. The latter is characterized by paroxysmal persistent cough with scant, tenacious sputum. The patient whose body adjusts itself to hypoxia during night, finds it difficult to move about and to do his usual morning routine.

Epigastric discomfort, often attributed to indigestion, may be due to hepatomegaly secondary to right ventricular failure and/or to diaphragmatic angina.

The larynx appears in a position lower than normal. This should not be interpreted as ptosis; rather it is brought about by the elevation of the anterior chest wall.

Distention of the veins on the undersurface of the tongue when the patient is sitting or standing was found by May (1943) a reliable sign of increased venous pressure. A convenient device for venous pressure determination was described by Blake and McLain (1958) and a bloodless method for this purpose was reported by Verhave (1959).

Reference has been made to functional changes characteristic of this disease. Their determination, together with studies of blood gases, adjunct hematologic and biochemical tests are of inestimable value in accurate diagnosis. Some ingenious innovations and easy applicability of new instruments in this field deserve mention. The instrument of Wang and Shipley (1958) is simple, portable, inexpensive and measures vital capacity of the lung, timed expiratory capacity and maximum expiratory flow rate simultaneously. Fleisch's (1960) improved pneumotachograph for determining the speed of respiratory air flow was developed from the first instrument of its kind in 1925, 1929, 1931. Fleisch's metabograph measures vital capacity and its subdivisions, maximum expiratory volume per second, maximum ventilation capacity and basal metabolism. Conant (1960) describes a new motor-

operated device which gives rapid graphic recordings of multiple timed-vital capacity measurements at one sitting, which can be interpreted without calculations. Stonehill and Reed (1960) attest to the simplicity and reliability of the Warring-Siemsen Ventube and of the McKesson-Scott vitalometer for evaluation of ventilatory function.

Treatment

Adequate management of emphysema requires prompt control of concomitant pulmonary infection, polybechia (excessive cough) and allergy, with proper correction of tussive insufficiency.

Smoking should be stopped. Slimming is mandatory in obese patients.

Removal of harmful environmental pollutants or removal of the patient from polluted atmosphere or climate may bring about some symptomatic relief.

Treatment of bronchospasm is bound to be of substantial benefit. Bronchospasmolytic drugs can be given by aerosolized inhalations or by micronized powder inhalations. Good results can be expected from sublingual administration of isoproterenol or from oral administration of ephedrine with one of the barbiturates.

My experience with diethylmethylammonium bromide, an anticholinergic drug, has been favorable. It is well known that acetylcholine is one of the basic agents in the causation of bronchospasm.

Corticosteroids, cortisone, hydrocortisone, prednisone, prednisolone, methylprednisolone, triamcinolone, dexamethasone have been found effective in the symptomatic treatment of emphysema by a great many clinicians. These drugs are capable of relieving bronchospasm as well as decreasing edema and inflammation of bronchial and bronchiolar mucosa. It is advantageous to combine bronchospasmolytic drugs with one of the corticosteroids.

When other means fail to relieve dyspnea, humidified oxygen is given through a nasal catheter. At the outset the flow rate is set to one liter per minute. It should be increased by one liter per minute daily until six liters per minute is reached.

To Motley and his associates (1948) belongs the credit for introducing intermittent positive pressure breathing as a therapeutic measure. Since then, often with the addition of aerosolized bronchospasmolytic drugs, it has been in use as a useful method for increasing alveolar ventilation, aiding broncho-catharsis and for improving pulmonary distribution of aerosolized antibiotics. Intermittent positive pressure breathing not only prevents increase in hypercapnia but also it is capable of reducing it in the great majority of cases.

A new method, namely exsufflation with negative

pressure, was introduced by Barach (1955) for the alleviation of dyspnea. Its efficacy in improving ventilation and facilitating bronchocatharsis has been corroborated.

For years, I have been teaching my patients pursed-lip expiration, a method first advocated by Schuetz (1935). It means ventilatory retraining of the patient: deep inhalation followed by very slow expiration through a very small opening between the lips. With proper instructions and thorough practice, much benefit can be derived from this simple measure. It improves intrapulmonary distribution of air because small bronchi and bronchioles are distended. It facilitates diaphragmatic function through forced increase in the intra-abdominal pressure. By increasing intrapulmonary pressure, occlusion of small bronchi and bronchioles is prevented during expiration.

Another physical measure may be helpful, namely manual compression of the lower anterior part of the chest and the upper part of the abdomen, rhythmically and corresponding to forceful volitional, slow exhalations.

All orthorespiratory exercises should be carried out with circumspection. When the patient is being taught forceful, slow expiration, one should be aware that too much muscular effort produces excess carbon dioxide and thus it may be unsuccessful in relieving hypercapnia. It is well to give bronchospasmolytic drugs prior to or during respiratory training periods. Barach (1959) advocates administration of oxygen at the same time.

Improved function of the diaphragm and thus relief from dyspnea are attainable by having the patient lie in a slanted, head-down position. The foot of the bed is elevated 18 inches.

In ambulatory patients with severe emphysema I have obtained highly satisfactory results with artificial pneumoperitoneum. The latter refunctionalizes the previously defunctionalized diaphragm and may decompress some of the large air cysts in the lung.

Whittenberger and his associates (1949) succeeded in improving ventilatory function of the lung by "electrophrenic respiration," that is, by electrical stimulation of the diaphragm, the muscles of the anterior abdominal wall and of the thoracic wall.

Gordon (1934) and Kountz and Alexander (1934) first recommended abdominal belt for aiding the function of the diaphragm. Since then, a number of improved abdominal supports have become available. An exsufflation belt devised by Fraimow and his collaborators (1960) is recommended in combination with intermittent positive pressure breathing.

Conflicting reports have been published on car-

bonic anhydrase inhibitors in the treatment of respiratory acidosis associated with emphysema. Acetazolamide, ethoxzolamide, dichlorphenamide belong in this category. Although these drugs do not significantly change pulmonary output of carbon dioxide, hypercapnia may be relieved by their diuretic action. Possibly, improvement in the patients' condition following the administration of acetazolamide may be due to its capacity of lowering oxygen consumption. The latter was demonstrated by Tenney and Tschatter (1959) in animal experiments.

A new organic buffer, trihydroxymethylaminomethane (THAM), has been used successfully by Manfredi and his co-workers (1960) for correcting respiratory acidosis and hypercapnia in severely ill patients. This drug is given intravenously as a solution of 0.33 molar in 0.2 per cent sodium chloride (pH of 10.38) at a rate of 300 ml. per hour for one to three hours.

The use of radioactive iodine, I^{131} , and thiouracil has been advocated for the purpose of reducing thyroid function and thus the metabolic rate, oxygen demand and respiratory distress.

Hypervolemia and rapidly rising venous pressure may be relieved by the administration of ammonium chloride, mercurial diuretics or by phlebotomy.

Lasting benefits may be derived from certain types of surgical measures. These include tracheal fenestration, excision of bullae and blebs, resection of the pulmonary plexus in combination with resection of bullae, reduction of the lung volume by resection of the most functionless areas of the lung together with denervation of the lung by resection of pulmonary vagal and sympathetic nerve branches, drainage of large bullae by the Monaldi technique, resection of the carotid body.

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American Academy of Pediatrics Speaks on Fluoroscopes

Attention has been called to the recent approval by the American Academy of Pediatrics of the recommendations of their Committee on Radiation Hazards and Epidemiology of Malformations for publication as the official position in the Academy with respect to the use of fluoroscopes in pediatricians' offices.

The American Academy's position is as follows, quoted from their News-Letter of June 1961:

"I. The American Academy of Pediatrics advises against the installation of fluoroscopes for use in pediatricians' offices except under unusual circumstances.

"II. The American Academy of Pediatrics recommends that existing fluoroscopes in pediatricians' offices be examined by a qualified radiophysicist for both electrical and radiation hazards, that all necessary physical safeguards be instituted

promptly, and that the radiation output be posted conspicuously on or near the apparatus. Furthermore, it is recommended that fluoroscopes be inspected annually.

"III. 'Routine' fluoroscopy of children, or fluoroscopy for demonstration to parents is strongly condemned.

"IV. Pediatricians are urged to consult with their radiologic colleagues when radiologic or fluoroscopic examination is being considered rather than to attempt the procedure themselves. They are also urged to encourage their radiologic colleagues to keep in mind the special susceptibility of children's tissues to radiation so that the maximum information can be obtained from minimal radiation dose by employing all available and feasible advances in equipment and methodology."

THE STOMACH GAS BUBBLE ON THE NORMAL CHEST FILMS OF CHILDREN

Russell Wigh, M.D.; Henry S. Anderson, M.D., *Augusta*

Serious disease must be suspected in the child whose erect chest film shows no evidence of gas in the fundus of the stomach.

IN ROENTGENOLOGICAL INTERPRETATION, the physician attempts to find all the departures from normal. In the instance of the chest film he will frequently seek disease clues by inspecting the subdiaphragmatic portions of the abdomen which are registered on the roentgenogram. Where there is a change in the position of the gas bubble in the stomach or in the shape of the fundus of the stomach, a conclusion may be drawn that there is an extragastric pressure manifestation present or that intragastric disease exists.

There is a third consideration about the stomach bubble. It may be observed either to be present or to be absent; however, one has not heretofore been able to draw a conclusion as to whether its absence may or may not be significant.

Since an absent gas bubble in the pediatric age group might point to underlying disease, it was felt desirable to know the frequency in which gas was present in the fundus of the stomach.

The chest films of a large number of children between the ages of two and 13 years that had been considered as normal were inspected for the presence or absence of a gastric bubble. Only instances in which the chest films were obtained erect were analyzed. The films of the infant group were eliminated because they were obtained almost invariably with the baby placed supine. Films that were erect but unsuitably exposed were discarded. A final total of 519 chest films of different children between the ages of two and thirteen years which contained no evident pulmonary or cardiac abnormality and which had been exposed with the child erect were included in the study.

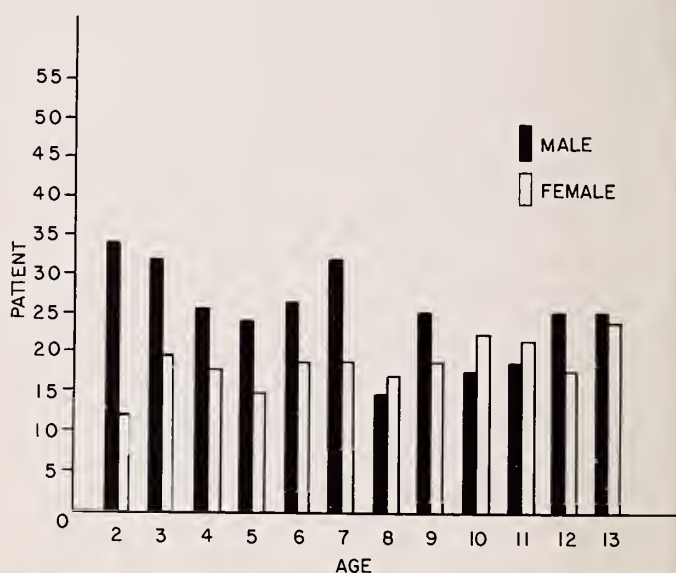


Figure 1. Age and Sex Distribution of 519 Children Whose Chest Films Were Examined for the Presence or Absence of a Stomach Gas Bubble.

The chart in figure I shows the sex and age distribution of the children. Of the 519 patients, 296 were males and 223 were females. The age distribution is fairly even for each year.

Although the size of the gastric air bubble varies greatly, usually its position is rather constant in the normal child (Fig. II). The degree of distention of the gas filled fundus will vary, particularly with the amount of air that is swallowed. Stomach gas is derived from three sources¹. Swallowed air accounts for 68 per cent; food decomposition and diffusion from the blood stream account for the remainder.

Observations

In the 519 children, the gas bubble was present on the normal chest films in 501 instances. This represents 96.5 per cent of the total. The sampling

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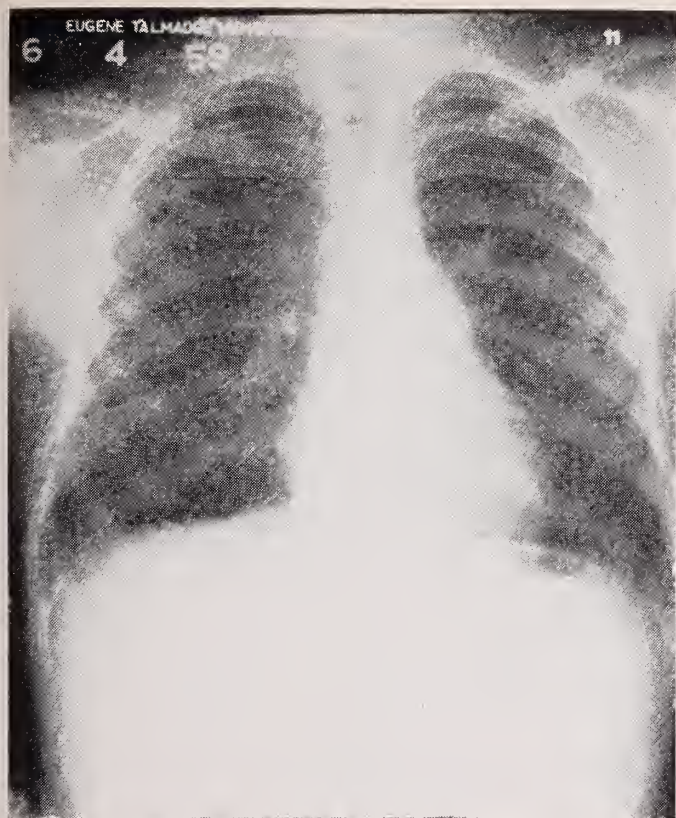


Figure II. The Film Demonstrates an Average Gas Collection in the Gastric Fundus.

is sufficient so that the percentage is considered statistically valid².

In 15 cases, (2.9 per cent) gas was not present in the fundus of the stomach; in two other cases its presence or absence was indeterminate because of large quantities of splenic flexure gas superimposed over the anticipated position of the gastric fundus. In the remaining case, although the chest exposure was adequate, abdominal obesity precluded a definite decision.

In figure III the chart lists the diagnoses or abnormalities which were present in the 15 patients in whom a perceptible gas bubble could not be recognized on the chest films.

Diagnosis	Number of Patients
Nephrosis	6
Splenomegaly	4
Obesity	2
Nausea and Vomiting of Undetermined Etiology	1
Fever of Unknown Origin	1
Epilepsy	1

Figure III. Coexistent Abnormalities in 15 Patients Without Stomach Gas.

Since the absence of gas in the stomach in just 15 instances might be simply on the basis of chance, those films of all patients in the age group under study who had nephrosis, splenomegaly, obesity or epilepsy were reviewed which were made in the erect position. The analysis of these films is condensed in figure IV.

Diagnosis	Chest Films Available	Gas Bubble		
		Present	Absent	Indeterminate
Nephrosis	22	16	6	0
Splenomegaly	22	18	4	0
Obesity	5	2	2	1
Epilepsy	13	10	1	2

Figure IV. This chart includes all of those patients among the 519 who had the listed diseases and indicates the frequency of an absent gas bubble.

Whereas in the original sampling only 15 of 519 patients had an absent gas bubble, ten of the 44 patients with nephrosis or splenomegaly had this sign. Since the latter proportion is so much larger, the difference cannot be considered as accidental. The absence of gas in the stomach in only one of the 13 epileptic children is probably mere chance. Although a fairly high ratio of the patients with obesity did not have fundal gas it could be argued that film contrast was inadequate in these two patients.

Discussion

Figure V.a. is that of the chest film of a patient with nephrosis. The stomach air bubble is absent. Three weeks later, as demonstrated in Figure V.b., following response to treatment, the air bubble is present. This was noted in several of the cases of nephrosis and was also observed in patients with splenomegaly due to leukemia and lymphoma after treatment. Most of the patients with splenomegaly had a gas bubble present but it was displaced or distorted.

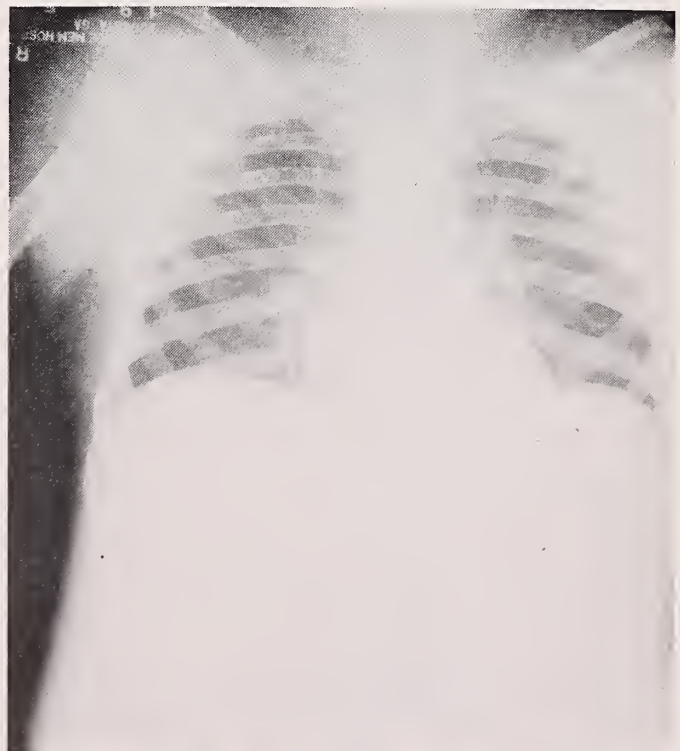


Figure V. a. The Chest Film of a Patient with Nephrosis does not Demonstrate a Gas Bubble in the Stomach.

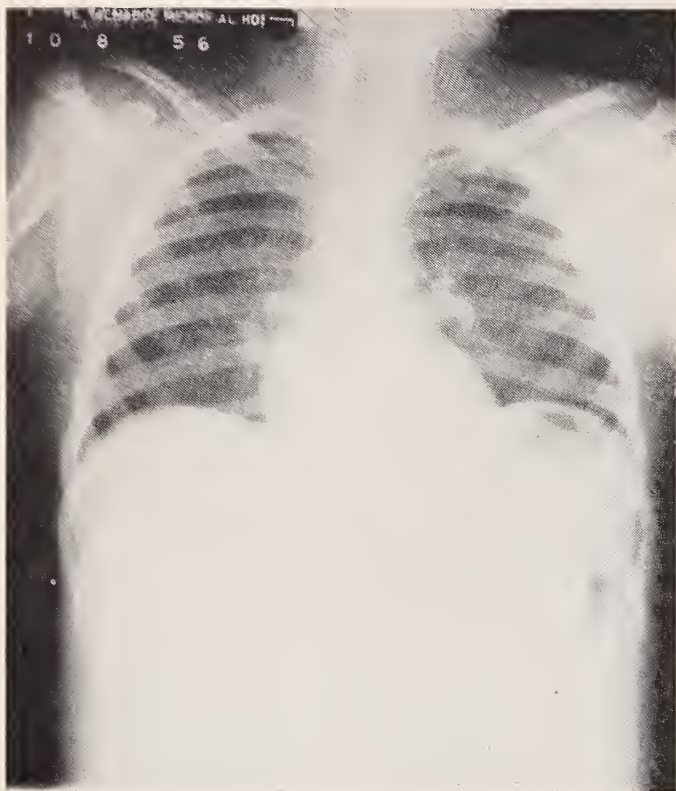


Fig. V. b. Three Weeks After Treatment, the Gastric Air Bubble Is Seen.

No doubt, there are some instances in which a gas bubble will be absent because of either eructation or because of vomiting prior to the time of exposure of the film. It would appear that in the majority of instances in which gas is not present in the fundus in patients who are examined erect that

the cause is due to splenic enlargement or to ascites. Observations in a different category of patients, those with acquired or congenital heart disease who were in failure, indicate that frequently the gas bubble is absent in them as well. (These examples are not included in these statistics since the chest films were not considered normal).

It is, therefore, predictable on a statistical basis that the absence of gas in the fundus of the stomach in children in whom the chest film is obtained erect will most frequently be indicative of the presence of serious disease. Although in the great majority of patients the diagnosis may well be known prior to roentgenological consultation, there is no doubt that there will be instances in which data concerning the frequency with which the gastric air bubble is seen will be helpful. The absence of such gas on a normal chest film will generally be found to be associated with nephrosis or other conditions producing ascites, leukemia and lymphoma.

Summary

The erect chest films of 519 children between the ages of two years and 13 years in whom there was no evident intrathoracic abnormality were reviewed. Gas was present in the stomach in 96.5 per cent. When gas is absent a serious underlying cause must be excluded.

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Eugene Talmadge Memorial Hospital

Medical Education Making Strides

The sharp warnings issued by well-known medical educators that we must rapidly increase the number of medical school graduates and establish at least 20 new schools in order to produce 3,600 additional physicians a year by 1975 in order to maintain the present physician-population ratio, are beginning to yield some tangible results.

Rutgers and Brown Universities have announced plans are underway to offer two-year programs in the basic medical sciences.

The University of New Mexico is fast making strides toward starting a two-year program in the basic medical sciences by appointing as dean, Dr. Reginal H. Fitz, associate dean of the University of Colorado School of Medicine.

San Antonio, Texas won a long-sought drive to locate a medical school in that city recently when a deed for 100 acres of land for the school was presented to the University of Texas. Formal cere-

monies dedicating the grounds to the construction of a medical center were held Aug. 19, with Dr. Joseph C. Hinsey, director of the New York-Cornell Medical Center being one of the principal speakers. The state legislature has appropriated \$1.85 million to begin the medical school.

While states such as Maine, Massachusetts, Michigan, Minnesota, Idaho, Ohio, and New York are studying the possibilities of establishing new medical schools, the Connecticut Legislature went into action by appropriating \$2 million to help start a new medical-dental school to be affiliated with the University of Connecticut. This amount, coupled with a \$1 million grant from the Kellogg Foundation, will enable the university to actively start work on the four-year medical school.

The University of Arizona has been selected by the Board of Regents as a medical school site, "if and when funds are available."

FOOD SENSITIVITY AS A CAUSE OF BRONCHIAL ASTHMA

Lamar B. Peacock, M.D., *Atlanta*

It is possible for multiple small allergens, anyone of which would not cause trouble, to add together and produce symptoms.

IN A TYPICAL ATOPIC ALLERGIC individual one sees a characteristic group of symptoms beginning in the first few days of life and often extending throughout the individual's entire life span. By atopic we mean familial or an inherited type of allergic reactivity. One does not inherit specific sensitivity but rather the predisposition to become sensitive to various foods, inhalants and other material.

The first symptoms and signs of allergic disease are usually gastrointestinal. One sign is the regurgitation of food. Here nature is simply rejecting the material offered. Another sign of allergy involving the gastrointestinal tract is what is termed colic. A child, within 15 to 20 minutes after eating, begins to cry, develops a hard, rigid abdomen, and may spend several hours in obvious pain and distress. Hours later the child may quiet down and rest, but with a new feeding the colic again ensues and the same symptoms repeat. At times diarrhea may be present where the colon is trying to rid itself of the offending allergen. Another sign is excessive mucus in the intestinal tract due to irritation of the mucosa from foods containing allergens. The mucosa tries to protect itself with the coating of mucus, thus avoiding the offending chemical.

The simplest and best approach to this problem is cognizance of the above fact! Every effort should be made to find foods that the individual will tolerate without gastrointestinal allergic symptoms. In sim-

pler words, foods should agree and not disagree with a child.

Secondly, if the offending food is not removed the symptoms may eventually shift from the gastrointestinal tract into the area of the skin. Atopic eczema often follows the gastrointestinal symptoms. This may begin in the second week of life or may not occur until around the end of the first year. The initial skin lesions are usually on the cheeks, followed shortly by a dermatitis around the ears, in the elbow areas anteriorly, and in the popliteal region. The child begins to itch from skin edema, scratches, and then produces eczematoid dermatitis with erythema, edema, scaling and weeping. Many of these children may have urticarial wheals associated with the eczema. This is often mislabeled by the dermatologist as neurodermatitis. It can be flatly stated that nervous tension is not a cause of this illness though it may be an aggravating factor. The allergic dermatitis is a cause of nervous tension, not vice versa. Another misconception is that children, if left alone, will outgrow their allergic reaction to foods. While the site of allergy may shift later from the skin to the bronchial tree the allergy is still present but in a different location. Our efforts, therefore, should be made to eliminate the allergy entirely and the term "outgrow" should not be used.

At this point a simple word concerning maternal rejection. It is often said that this eczematoid dermatitis is caused by a mother's rejection of a child. This is not true. It is only natural for a mother to

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reject, to a degree, a sick child, particularly one who causes many sleepless nights. It is the eczema that produces the rejection not the reverse.

If the eczema is not controlled and the foods are not eliminated at this point, the third stage is allergic rhinitis. Here we see the typical young child who walks around with a runny nose, who has a "cold all of the time", and who has repeated respiratory infections. This may persist for several years, even up into the grade level of school or further. Examination of the nose shows pale and swollen membranes with a white, clear discharge. The passages may be completely occluded and the child often is a mouth-breather. The features of the face are altered and the lips are perch-like and puckered, with chapped lips due to excessive mouth breathing.

The fourth step is a further move down the respiratory tract into the larynx and trachea. The child has frequent coughs, frequent infections in the respiratory tract. From here allergic disease moves into the larger bronchi and into the small bronchioles. The most common diagnosis here would be acute bronchitis or bronchiolitis. If infectious, it generally is superimposed on the original allergic edema and excessive mucous secretions in the bronchial tree. These mucous secretions produce obstruction and with obstruction in any tract, infection invariably ensues.

From bronchiolitis the next, fifth, and final step is into the periphery of the lung with resulting allergic pneumonitis and bronchial asthma.

It should be noted that there is no difference between allergic rhinitis and bronchial asthma except in location. It is the same disease and can be prevented in the same manner.

The best means of prevention of bronchial asthma is recognition of early gastrointestinal symptoms of colic and regurgitation and the finding of a satisfactory formula and diet for each child, a diet which will be well tolerated without any significant allergic symptoms. By doing this, food skin testing can be avoided with all of its many pitfalls. If it is not done and the child is seen later in life, food skin tests are helpful and should be performed.

Sensitivity at Birth

It is often asked why a baby may be sensitive to foods at birth. One has but to remember that the child grew to its initial six or seven pounds on the food from the mother. Sensitivity, therefore, can occur in utero to the various chemicals absorbed from the mother's blood stream. This does not mean that the child will be allergic to the same foods or inhalants that the mother is, but it does mean that the child has a definite inherited predisposition to be

allergic. Statistically one allergic parent and one non-allergic will produce approximately 50 per cent allergic children. Two allergic parents will produce clinical findings of allergy in approximately two-thirds or more.

Importance of Milk Composition

In initial consideration of feeding of the child one must keep in mind the composition of milk and also the components of the entire formula. Milk is not a single chemical. It varies day by day, depending on what the cow eats. Certain chemicals are present in all cow's milk. Casein is found in all milk and cannot be destroyed by heat or by processing. If a child is allergic to casein the only means of control is complete elimination of milk and milk products.

Other proteins such as lactalbumin and lactoglobulin are heat labile. While pasteurization will not destroy them, boiling or evaporation usually will destroy most of them. There are other proteins in milk not yet identified.

In addition to this, one must remember that whatever the cow eats is also present in the milk. Any dairy farmer will tell you that bitterweed is easily tasted in milk following oral intake by the cow. Wild onion in the spring is tasted in milk, and, while bermuda grass cannot be tasted, it is still present when eaten. This offers a very logical and scientific explanation for the fact that some children can drink milk on one occasion and not on another. Quite often milk from the same cow will vary greatly in its chemical content. Remember that penicillin injected into a cow will contaminate the milk for several days. If a child were allergic to penicillin and drank milk from this cow, he might have some type of allergic response.

Formulae for babies generally contain corn syrup. While this is not as major an offender as other fractions of corn, it is still a common cause of allergic rhinitis as well as colic. Corn syrup should not be overlooked in the attempt to discover all food allergens. Vitamin mixtures are also a source of allergy. You are dealing with chemicals and again you are dealing with multiple chemicals in a given unit.

In a suspected allergic child the foods should be added one at the time, preferably a pure whole food, and this food should be tested clinically for at least a week. The common fallacy of feeding children early on a multiple group of foods is one of the major causes for our failure to appreciate and pick up food sensitivity as a cause for allergic disease.

In discussing allergy to foods as a cause of asthma one must remember that there is a quantitative

as well as qualitative reaction. For instance in individuals allergic to egg, the sensitivity may vary from person to person. Some people are so sensitive to egg that even one tiny drop on the head of a pin can cause a severe asthmatic attack. Other patients might have to eat a dozen eggs before they would have the first symptom of either allergic rhinitis or bronchial asthma. This normal intake in these patients would cause no symptoms.

Another entity to keep in mind is what is termed the allergic load. Every person can resist a certain amount of allergens, just as one can resist a certain number of bacteriae and virae. It is only when the body's resistance is completely overwhelmed by allergy that symptoms ensue. A person, therefore, might eat chocolate this week, have no trouble, but then the following week could have severe difficulty on eating chocolate. The cumulative effect was more than he could handle. By similar logic, mild food allergens can be spaced and never allowed to

reach the level of clinical allergy. At the same time it is possible for multiple small allergens, any one of which would not cause trouble, to add together and produce symptoms.

Miscellaneous signs and symptoms of food sensitivity should include cradle cap or eczema of the scalp, aphthous ulcers of the mouth, motion sickness, repeated ear infections, hearing loss, tinnitus, and symptoms of the central nervous system even including convulsive seizures.

Allergic children are often accused of being nerotic. On the other hand keep in mind that chronically ill patients develop a neurosis as a result of their illness, not vice versa. Approach a child born of allergic parents with the above scientific knowledge and, through avoidance of food allergens, prevent impending bronchial asthma and pulmonary insufficiency.

478 Peachtree Street, N.E.

NEW MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

<i>Name</i>	<i>Address</i>	<i>Classification</i>	<i>County Society</i>
Albert, Bernard L.	Communicable Disease Center Atlanta 22, Ga.	Service	DeKalb
Baumgaertel, Karl T.	Milledgeville State Hospital Milledgeville, Ga.	Active	Baldwin
Bennett, Garland P., Jr.	231 E. Ponce de Leon Ave. Decatur, Ga.	Active	DeKalb
Cox, Ross J.	Gearheart Bldg. Atlanta 19, Ga.	Active	DeKalb
Griffin, John B., Jr.	2829 E. College Ave. Decatur, Ga.	Active	DeKalb
Huff, Prentis B.	Decatur Federal Building Decatur, Ga.	Active	DeKalb
Joel, Charles, Jr.	441 W. Peachtree St., N.E. Atlanta 8, Ga.	Assoc.	Fulton
MacKinnon, Irvile H.	Milledgeville State Hospital Milledgeville, Ga.	Active	Baldwin
Matthews, W. Frank	DeKalb General Hospital Decatur, Ga.	Active	DeKalb
McDonald, Lawrence P.	36 Butler Street, S.E. Atlanta 3, Ga.	DE-2	Fulton
Miller, Aloysius I.	Brawner's Sanitarium Smyrna, Ga.	Active	Fulton
Minor, Byron D.	36 Butler Street, S.E. Atlanta 3, Ga.	Active	DeKalb
Rairigh, Donald W.	3990 Buford Highway Atlanta 6, Ga.	Active	DeKalb
Raitz, Robert L.	Burleyson Drive Dalton, Ga.	Active	Whitfield
Spanier, Jacob A.	36 Butler Street, S.E. Atlanta 3, Ga.	Active	Fulton

PSORIASIS

William L. Dobes, M.D., *Atlanta*

The current status of modern methods of treatment is discussed.

DURING THE PAST 20 YEARS, we have witnessed revolutionary changes and marked progress in the diagnosis and treatment of many diseases. Some progress has been made in the treatment of psoriasis, although many major obstacles are still to be overcome. Psoriasis still remains a common disease, is chronic, recurrent and often difficult to clear. As yet, we cannot claim a cure for this condition. Much has been added to explain the pathology of the psoriatic process, but the true etiology still remains obscure. Regardless of what method is used to clear the disease, relapses are common. We also know that psoriatics often tend to develop a resistance to previous medications. In those cases, the modality of treatment must necessarily be changed. Each individual case must be evaluated. Many persons have only a few patches of psoriasis and usually clear up under local treatment. The patient with a severe or treatment resistant case of this skin disease would be well advised to adopt a long range program of patient attitude and prolonged care. Psoriasis has a definite psychosomatic component. The tense, frustrated, and anxious patient usually does not do so well. The use of mild sedation or tranquilizing drugs is proper in these patients. However, in most cases good local therapy is necessary along with an effort to improve the emotional health of the patient. General health should also not be overlooked. Foci of infection, organic dysfunction, and living habits still play an important role in many

cases of psoriasis. On the other hand, many cases will appear to be in perfect health except for the skin involvement.

After twenty years of experience in treating psoriasis, I have found many old measures still very useful although new approaches often are necessary. I would like to present some of these for your consideration.

Lesions of chronic psoriasis on open areas of glabrous skin are treated with:

- (1) Rx ammoniated mercury five to ten per cent.
Salicylic acid two to four per cent.
Tween "80" one half per cent.
Zinc oxide ointment or aquaphor q.s.
- (2) Anthralin 0.1 to 0.25 per cent ointment.
- (3) Alphosyl Lubricating Cream (Reed & Carnick) which contains crude coal tar and Allantoin.
- (4) Various modifications of the Goeckerman treatment. This is particularly useful in generalized cases.

The night before exposure to sunlight or artificial ultraviolet light, the patient applies a five per cent coal tar ointment. This treatment can be repeated daily. One must be cautious not to overexpose the photosensitized skin to ultraviolet light. The ultraviolet light exposures should be timed and gradually increased to a suberythema dose. Severe erythema or burn should be avoided.

I find useful a combination of mineral oil and a keratin moisturizing fraction of lanolin (Alpha keri, Westwood Pharmaceuticals) to which crude coal tar or liquor carbonis detergens has been added. This preparation is acceptable to the patient and

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Chairman's Address—Georgia Society of Dermatologists.

is in lieu of the crude coal tar ointment. Also this combination is very useful in treating psoriasis in the scalp. This is accomplished by massaging into the scalp a liberal amount of the tar-oil mixture and wrapping a hot towel around the scalp. The warm oil softens and helps remove the scales, allowing subsequent medication to penetrate and act more effectively. A tar shampoo, Betadine shampoo or tincture of Green Soap are used for washing the scalp.

This tar-oil can be used with benefit not only in generalized psoriasis but also as a preventative measure when one or two tablespoonfuls are added to a tub of lukewarm water before bathing.

In intertriginous psoriasis, I find Vioform creams and Liquor Carbonis Detergens creams of value. If inflammation is pronounced, the incorporation of Hydro-cortisone is most helpful. Roentgen ray irradiation in subfractional doses is effective in most of these cases, whereas it is usually contra-indicated in other areas with the possible exception of some cases of scalp and nail involvement.

Diets and various oral medications have been recommended through the years by various authors. With further clinical trials, most of these drugs have proven to be valueless except for the part that they may have played as psychotherapeutic agents.

Exceptions Worth Considering

There are some exceptions worth considering. In obese patients, a low caloric diet is frequently beneficial. If the blood cholesterol is elevated, a low fat diet may be beneficial. Some psoriatics and especially those with psoriatic arthritis may find relief in taking thyroid. I prefer the whole dessicated thyroid. I start my patients with one fourth grain tablet and every two or three days increase the dosage by grain one fourth until tolerance is reached. Many psoriatics will tolerate thyroid extracts in fairly large amounts and improve, even though the tests for thyroid dysfunction are negative. We apparently deal here with a hypo-metabolism not related to thyroid deficiency. Cytomel usually can be used in place of thyroid extract with good results.

Large doses of vitamin D also will improve an occasional case of severe psoriasis and often relieve the discomfort of psoriatic arthritis. In adults, 100,000 units daily should be used. Many dermatologists also add to this 100,000 units of vitamin A and 500 mgm of vitamin C daily. Although my series of cases is small, this combination seems well worth a trial.

Drugs of undisputed benefit are the steroid hormones with their anti-inflammatory effect and the folic acid antagonists aminopterin and methotrexate. Psoriatic lesions will clear rapidly with large doses

of steroids, but unfortunately recurrences are frequent and often more severe than the original eruption. The common side effects of prolonged steroid therapy are well known.

The folic acid antagonists in larger doses also will clear psoriasis, but too frequently the patient develops aphthous like ulcers in the mouth and occasionally a transient but embarrassing loss of hair.

In an attempt to avoid unfavorable reactions, I have combined the two drugs in smaller dosages with few minimal reactions and a high percentage of success. This oral therapy is reserved for severe cases and treatment resistant cases.

I prescribe aminopterin one 0.5 mgm tablet a day for two weeks. During this time, four triamcinolone tablets are given daily for the first two days, then three daily for two days, two daily for two days and one daily for eight days. At the end of the two weeks, the aminopterin and steroids are discontinued. After one week's rest, the routine may be repeated.

Up to date, I have treated over 120 psoriatic patients with the combination of drugs. The dosage in the beginning varied, but never was a daily dose of triamcinolone greater than 16 mgm. Thirty cases treated with the suggested routine were followed for eight months or longer.

Reactions to the suggested dosages were uncommon. While taking 16 mgm of triamcinolone a few cases complained of gastric distress, flushing, headache or restlessness. The symptoms disappeared when the daily dosage was decreased. Contra-indications to the use of triamcinolone were history of stomach ulcer or other severe gastro-intestinal disease, past or present pulmonary tuberculosis or chest disease, diabetes, severe hypertension, or psychiatric disturbances.

Eight Cases Developed Aphthous Ulcers

Eight cases developed aphthous ulcers from the aminopterin. These promptly healed when the drug was discontinued. Twenty-eight cases of the 120 cases developed a mild stomatitis or burning of the mouth and tongue. The drug was again tolerated after a rest period.

One case developed a total alopecia which was alarming to the patient. The psoriasis cleared and the hair regrew.

Once cleared or considerably improved, 65 per cent of the patients would remain so for three months or longer, if local measures were continued. An attempt was made to keep the recurrences at a minimum with local treatment, rather than continue or repeat the oral therapy of triamcinolone. The aminopterin, if tolerated, was given again if

lesions showed a tendency to recur. Often, if indicated, two or three tablets a week would keep the disease under control.

Methotrexate, also a folic acid antagonist, often was substituted for aminopterin. The adult dose in psoriatics was one 2.5 mgm tablet once or preferably twice a day. This drug appeared to be not as effective as aminopterin. Unfavorable reactions, however, were less frequent.

Originally, small maintenance doses of triamcinolone were tried, but relapses and failures were too common.

Localized, treatment resistant plaques can be treated with intradermal (intralesional) injections of triamcinolone acetonide (Kenalog parenteral-Squibb) and triamcinolone diacetate (Lederle) in one to five per cent suspensions. Response in most cases is prompt and dramatic. Here again, local treatment is important and should be continued as the controlling agent.

Theoretically even the small dosage, long term triamcinolone therapy may cause some suppression of the adrenal function. If this is true, it is a safe rule that any patient that has received steroid therapy for seven days or more during the year, preceding any operation or during severe trauma, should receive prophylactic treatment to prevent effects of adrenal cortical insufficiency. I have seen, however, no ill effects in my series of cases, which I tried to follow up as closely as possible.

Conclusions

When steroids and aminopterin are prescribed, one must keep in mind that they should be used with caution and in small dosages only. It is unlikely that the small amounts of these drugs as recommended would precipitate serious trouble, but it is best to keep the contra-indications in mind. Conservative management is probably still the best policy, although in selected cases the oral therapy may prove to be the treatment of choice. The folic

acid antagonists are abortifacient and should not be given to pregnant women. These drugs are available by prescription to the physician only and must therefore be dispensed through one's office.

Any treatment for psoriasis will only accomplish a temporary clearing and not a cure. Most patients will be happy to have the exposed areas free of their unsightly lesions. If local treatment cannot accomplish this, prudent use of steroids and folic acid antagonists will, in a high percentage of cases. It is my opinion that the use of these drugs when properly administered, is safe and effective.

Summary

1. Local therapy of psoriasis as preferred by the author is given.
2. Severe cases and treatment resistant cases of psoriasis will often respond to a combination of triamcinolone and folic acid antagonists given by mouth.
3. The dosages should be small and treatment of short duration.
4. Small localized plaques can be treated successfully with intralesional injections of triamcinolone.

478 Peachtree Street, N.E.

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Nation's Oldest Essay Contest Offers \$500.00 Prize

The Trustees of America's oldest medical essay contest, the Caleb Fiske Prize of the Rhode Island Medical Society, announce two subjects for this year's dissertation, open to any doctor of medicine in the nation, for which a cash prize of \$500 will be awarded. The subjects chosen are: "RECENT ADVANCES IN THE TREATMENT OF MALIG-

NANT DISEASE," and "CURRENT STATUS OF CARDIAC SURGERY." An essay on either subject must be typewritten, double spaced, and should not exceed ten thousand words. Essays must be submitted by December 11th to the Secretary, Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

RELIEF OF DIARRHEA WITH DIPHENOXYLATE HYDROCHLORIDE (LOMOTIL)

Charles W. Hock, M.D., *Augusta*

The drug produced results superior to prior medications in 68 per cent of 41 patients.

DIARRHEA may be caused by dietary, mechanical, chemical, allergic or psychogenic factors, or by enteric infections. Whenever possible an etiologic diagnosis should be made and the appropriate remedy applied. However, the physician will usually treat these cases symptomatically and immediately, because neither he nor the patient wishes to postpone treatment for hours or days while diagnostic procedures are being carried out.

Treatment of acute and chronic diarrhea has most often been with either codeine or paregoric. Paregoric causes bowel spasm which in turn lessens frequency of stools. Codeine has a more physiologic effect and slows down the bowel so that it acts in a more normal fashion. This difference between the two drugs has been noted during many years of practice, with excellent results following codeine therapy and poor results following administration of paregoric. Codeine, however, has a recognized addicting potential.

Since these and other agents which have been used for control of diarrhea are either inadequate or have undesirable side effects, and since preliminary studies¹⁻⁵ on diphenoxylate hydrochloride* in this indication have been encouraging, a clinical trial was conducted to determine its effectiveness and the incidence of side effects associated with its use. The action of this drug on the smooth muscle of the intestinal tract is similar to that of morphine. Although no evidence of addiction liability has been

reported by clinical investigators, studies⁶ at the Addiction Research Center of the National Institute of Mental Health showed that high dosage (40 to 60 mg. daily) increased the addicting potential. As evidence of its safety in this regard, Lomotil is classified as an exempt narcotic.

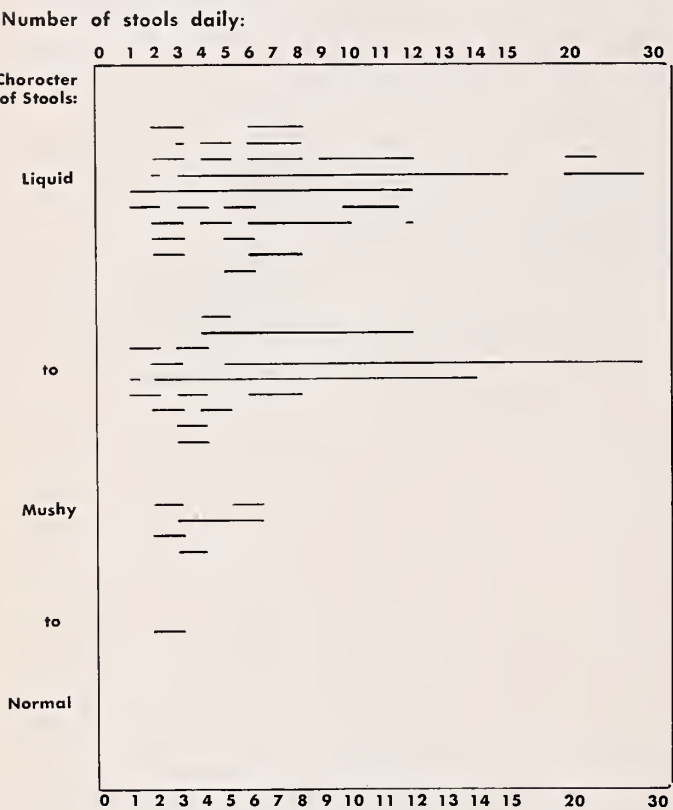
Material and Methods

Diphenoxylate was administered to 50 patients with diarrhea due to functional bowel distress (31 patients), viral gastroenteritis (seven patients), ulcerative colitis (five patients), and other etiologies (five patients). Circumstances of treatment or condition of two patients were such that they could not be included in the data to be presented. Of the remaining 48, 22 were males and 26 were females ranging in age from six to 74 years (mean, 42.5 years). Severity in terms of character and frequency of stools is shown in Table 1. Approximately one-third of the cases could be characterized as acute with duration of less than four days. Duration of the chronic cases varied considerably, but in the majority symptoms had been present intermittently for from three to 20 years. Many patients also had associated or unrelated secondary conditions which complicated management of the diarrhea. Diagnoses were established by x-ray studies of the gastrointestinal tract, gallbladder visualizations, barium enemas, sigmoidoscopy, stool cultures, urinalyses, Kahn tests, and blood counts.

* Lomotil®, G. D. Searle & Co., Chicago, Illinois.

RELIEF OF DIARRHEA / Hock

Table I. Severity of diarrhea as measured by character and frequency of stools. Each of the 48 patients is represented by a line, varying in length to show the range in the daily number of stools for that patient.



Nine of the patients had not been treated previously, 39 had received various antidiarrheal agents during prior therapeutic trials, and two had tried favorite home remedies. Previous medications had produced good results in 19 per cent, good to fair results in 17 per cent, fair results in 17 per cent, fair to poor results in 10 per cent, and poor results in 37 per cent.

Those patients on special diets were directed to continue these, and medications which had been prescribed for conditions other than the diarrhea were also continued. These included sedatives, tranquilizers, anticholinergics, antispasmodics, antidepressants, appetite depressants, antinauseants, anabolic agents, antacids, analgesics, antibiotics, sulfa drugs, and supplemental iron preparations. These medications had shown no effect on the diarrhea.

The initial dosage schedule was one five-mg. tablet of diphenoxylate four times daily. Exceptions were four patients who were either started on or increased to a daily dosage of 40 mg. Two patients varied their daily dosage between 10 and 20 mg., one took only 15 mg. daily, one took 10 mg. daily, and two took 7.5 mg. daily divided into three doses.

Results

Response to diphenoxylate therapy was considered "good" when there was complete or almost com-

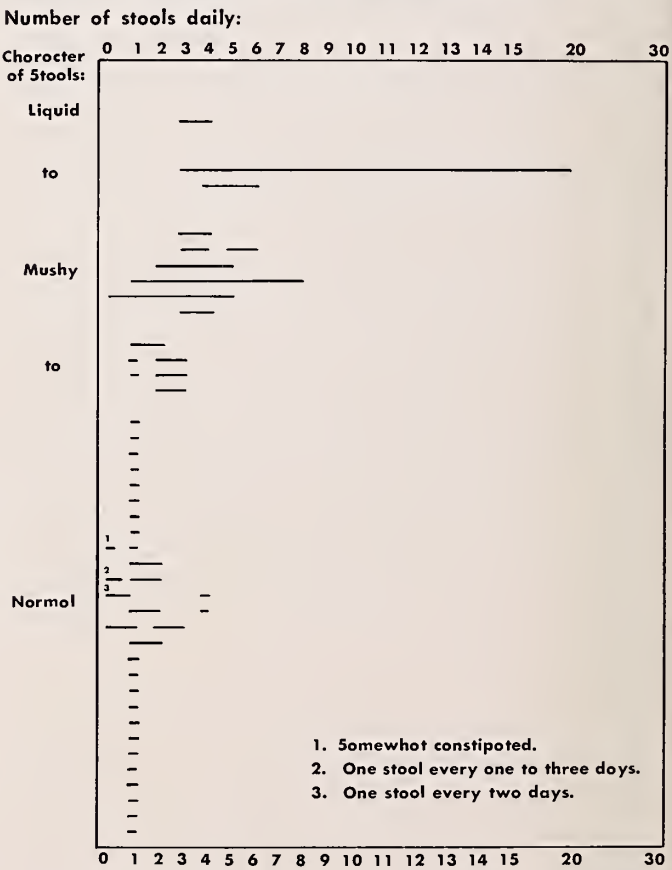
plete resolution of symptoms; "fair" when there was definitive improvement with moderate relief of symptoms, but mild residual discomfort; and "fair to poor" when reduction in symptoms was not sufficient to significantly alter the patient's discomfort. When there was no improvement, results were classified as "poor." Based on these criteria, good results were obtained in 83 per cent of the cases, good to fair results were obtained in 10.4 per cent and fair to poor results in 6.3 per cent (see Table II).

Table II. Response to Lomotil.

Etiology of Diarrhea	Results				Total
	Good	Good to Fair	Fair	Fair to Poor	
Functional bowel distress	27	2	1	1	31
Gastroenteritis, viral	7	—	—	—	7
Ulcerative colitis	3	1	1	—	5
Miscellaneous	3	2	—	—	5
	40	5	2	1	48
	93.7%		6.3%		

Improvements in items of character and frequency of stools can be seen by comparing Table III with Table I.

Table III. Character and frequency of stools after administration of Lomotil. Each patient is represented by a line, varying in length to show the range in daily number of stools.



Of 31 patients with functional bowel distress, four were classified as having fair or poor results. One of these had secondary diagnoses of duodenal ulcer, diverticulitis, and postcholecystectomy syndrome. Even though dosage was increased to 40 mg. daily, no improvement was apparent. A sim-

ilar response had been obtained with many other medications, including codeine. A second patient, with a secondary diagnosis of acute anxiety, failed to respond to 40 mg. of the drug daily. He had responded very poorly to every other medication; for him to admit any improvement was close to a therapeutic triumph. Twelve of the patients with "good" results had secondary diagnoses of antral gastritis, marginal or duodenal ulcer, hiatal hernia, diverticulitis, fissure-in-ano, cholelithiasis, or post-gastrectomy syndrome.

Three patients had viral gastroenteritis superimposed on functional bowel distress, a fourth superimposed on postbulbar ulcer. These four achieved good results as did the other gastroenteritis patients.

None of the five ulcerative colitis patients had any observable secondary disease conditions. Evaluation of these cases was difficult in that this disease has a tendency to natural remission. Classification of response is given with some reservations, while being as definitive as possible. The overall impression was that diphenoxylate gave gratifying results.

The five patients grouped under "miscellaneous" (see Table IV) represented one case each of regional ileitis, diarrhea of *Proteus* origin, diarrhea of either viral or functional etiology complicated by subtotal gastrectomy, tabes dorsalis, and malabsorption syndrome following intestinal resection for regional ileitis. The latter two had "good to fair" results, while the other three had "good" results.

Table IV. Efficacy of Lomotil Compared with Other Management in 41 of the Patients.

Etiology of Diarrhea	Same to		Better to		Not as		Total
	Same	Better	Better	Good	Good	Good	
Functional bowel distress...	4	2	20	1	—	—	27
Gastorenteritis, viral	—	1	5	—	—	—	6
Ulcerative colitis	1	2	2	—	—	—	5
Miscellaneous	1	—	1	—	—	1	3
	6	5	28	1	—	1	41
			(68.3%)				

A comparison of the efficacy of diphenoxylate and prior medications (Table IV) shows better results with Lomotil in 68.3 percent of the cases and "same to better" results in an additional 12.2 per cent. The "not as good" results occurred in the patient with tabes dorsalis; codeine was a more effective medication in his case.

The remaining two cases were not tabulated with the 48 just described for the following reasons: One patient, a 62-year-old woman with diabetes of many years' duration, died shortly after being seen. Diarrhea of unknown etiology had been present for nine weeks, and five mg. of diphenoxylate four times daily gave poor results although the number of stools decreased. The other patient had diarrhea

of viral origin superimposed on functional bowel distress. Treatment was started with a five-mg. intramuscular experimental form of diphenoxylate, whereas the remainder of the data is based on tablet therapy.

Side Effects

Side effects occurred in four patients (8.3 per cent). An increased dosage (40 mg. daily) caused nausea and severe burning sensation in the head associated with vomiting in one patient. Two others on a lower dosage complained of nausea. A fourth reported feeling "drunk" on the original dosage of 20 mg. daily. These reactions, while seemingly mild, were disliked by all these patients to the extent that they discontinued medication. The three other patients who were taking 40 mg. daily had no untoward effects. There was no evidence of potentiation in those who were taking barbiturates.

Since diphenoxylate has been classed as a narcotic, particular attention was directed toward observation of any habit-forming properties. There was no indication that the drug was in any way habit-forming. Even when patients who had used the drug for a number of months were without it for several days, they did not make any effort to secure an additional supply. It is likely that they would have displayed a marked tendency to do so if the drug were addicting.

Discussion

In general the response to diphenoxylate has been very favorable, with diarrhea responding promptly to the medication. In acute episodes, patients usually began to feel more comfortable and the desire to defecate was diminished after approximately one hour. In diarrheas of a recurrent type many patients reported relief after a single five-mg. dose of diphenoxylate. In those of a more continuous type, response required more prolonged therapy.

Since diphenoxylate acts in a fashion almost identical with that of codeine, it is a highly desirable medication. Experience in this study confirms this opinion. Even where codeine has previously given good control of diarrhea, diphenoxylate may provide an improvement in medication since it may not leave the sickish-nauseated feeling that codeine frequently causes.

Summary

Treatment of diarrhea in 48 patients with diphenoxylate hydrochloride (Lomotil) gave good results in 83.3 per cent, good to fair results in 10.4 per cent, fair results in 4.2 per cent, and fair to poor results in 2.1 per cent. The drug produced results superior to prior medications in 68.3 per cent of 41 patients. The presence of severity of secondary conditions showed no consistent effect

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on results of therapy. Side reactions were infrequent, but the four patients who experienced them stopped taking medication. There was no evidence of addiction potential or of potentiation of barbiturates.

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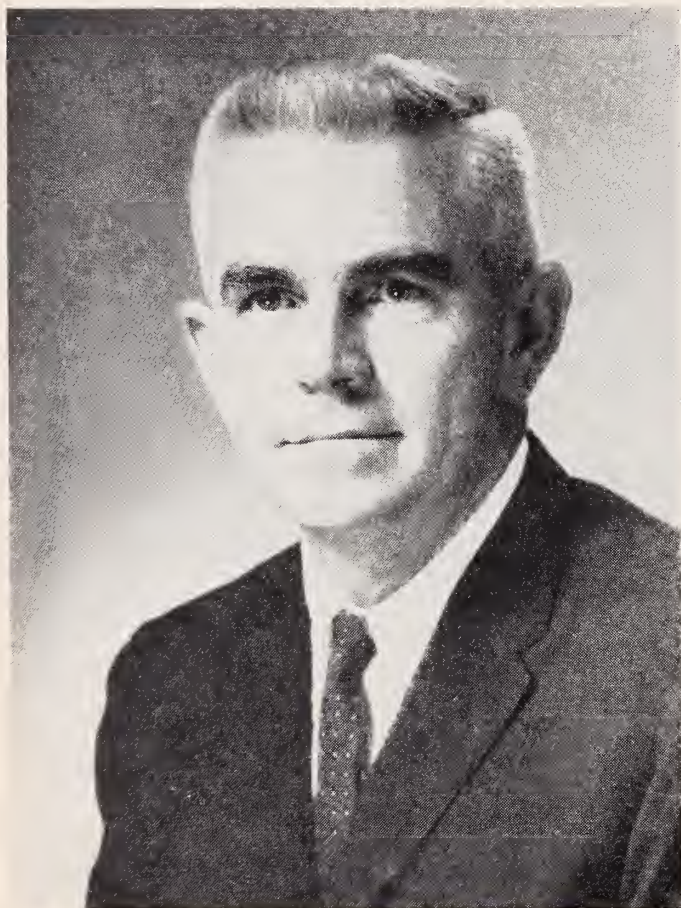
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Clarence C. Butler, M.D., of Columbus, Elected President of G.H.A.



Clarence C. Butler, M.D.

Dr. Clarence C. Butler of Columbus is the new president of the Georgia Heart Association, a voluntary health agency dedicated to the fight against the heart and blood vessel diseases.

Dr. Butler succeeds Dr. Arthur M. Knight, Jr., of Waycross.

The election took place Saturday during the heart association's 13th annual meeting, held this year at Jekyll Island and attended by nearly 500 physicians, volunteer leaders and other guests.

Dr. William B. Fackler, Jr., of LaGrange was named president-elect, and Carter L. Redd, Atlanta,

was re-elected board chairman.

Other officers include Dr. John L. Elliott, Savannah, and Brunswick, A. Bagdon, Atlanta, vice presidents; Dr. Louis L. Battey, Augusta, Secretary, and James D. Robinson, Jr., Atlanta, treasurer.

Elected to the board of directors were Dr. Harry H. Brill, Jr., Columbus; Dr. Harry W. Faulkner, Covington; Dr. Charles D. Hollis, Jr., Albany; Dr. Charles R. Ireland, Macon; Dr. Oscar M. Mims, Thomasville; Robert Engeman, McDonough; Marion Stribling, Habersham; Carter L. Redd, Rease Inge, Gilbert McLemore and Rankin M. Smith, Atlanta.

Miss Inez Thornton, Elberton, president of the heart association's Northeast Georgia Chapter, and Thomas W. Lauderdale, Jr., Savannah, president of the First District Chapter, automatically became directors because of the offices they hold.

Named as delegates to the Assembly of the American Heart Association were Dr. Louis L. Battey, Augusta; Dr. Simone Brocato, Columbus, and Carter L. Redd, Atlanta. Alternate delegates are Dr. Goodloe Y. Erwin, Athens; Dr. John L. Elliott, Savannah; Dr. J. Gordon Barrow, Dr. Haywood N. Hill and Dr. Joseph C. Massee, Atlanta.

During scientific sessions of the annual meeting, papers were read by Dr. Jesse E. Edwards, pathologist, St. Paul, Minn.; Dr. Alexander S. Nadas, pediatrician and cardiologist, Boston, Mass.; Dr. Edward D. Freis, cardiologist, Washington, D. C., and Dr. Earle B. Kay, thoracic and cardiovascular surgeon, Cleveland, Ohio.

Participating in a session for volunteers were Lewis F. Gordon, Jr., Atlanta, chairman; Warren Hites, Augusta, and O. J. Murry, Savannah, moderator; Dr. Clarence C. Butler, Columbus; Dr. Arthur M. Knight, Jr., and Dr. David P. Mason, Waycross; Tyus Butler, Athens; Dr. J. Gordon Barrow, Rease Inge and M. Linwood Beck, Atlanta.

PRESERVING YOUR HERITAGE — NOW OR NEVER

Milford B. Hatcher, M.D., Macon

Our system of free medicine has attained the highest quality of medical care for the most people of any system ever known.

MR CHAIRMAN, DISTINGUISHED GUESTS, Members of the Georgia Dental Association and Georgia Pharmaceutical Association, Fellow Physicians and Charming Ladies:

My job today is to speak to you; your job is to listen. If any of you get through before I do, hold up your hand.

The United States of America is now the only major country in the world which has a free type of medical practice, and you, as a practicing physician in the State of Georgia, a teacher in one of our medical schools, or a member of the State Health Department, are a member of this free profession. In America today a doctor *still* has a right to choose the location where he will practice, he *still* can choose the type practice he wants to do, he can *still* specialize, teach, do research, public health, or general practice if he chooses, and can even choose which patients he will treat. No bureaucrat behind a desk a thousand miles away can move you around like a peg and place you in this branch of medicine or in this location where he may think you should be. You are not subject to directives telling you how you will treat your patients. You are *still* a free member of a free profession in a free society. This is your heritage as an American physician, and this *heritage* and this *freedom* are what we stand to lose.

Those of us who have had occasion to study the problems facing the medical profession in America today and to talk with our legislators and other

governmental officials are *alarmed*—so much so that we felt it our obligation as your representatives to call this meeting and call to your attention the urgency—the now or never aspects—of our dilemma, the fact that your whole way of life is in danger of being changed. The first step toward socialization of medicine may be taking place in the very near future. Unless doctors themselves find a way of meeting this challenge, someone else will do it for them, probably not as well.

We are fortunate to have some very excellent and informed speakers with us today—and they will give you the details of the immediate problems we are facing.

I will be the first to admit that we do not have a perfect system and that everything is not as all of us would want it to be. However, our system of free medicine has attained the highest quality of medical care for the most people of any system ever known. Although there are areas where much improvement should be made, the overall picture is an amazingly satisfactory and successful one. With voluntary insurance plans by private enterprise, the number of people who can not obtain necessary medical care through private means has become an astonishingly small percentage of our population. Many of our problems have, indeed, been brought about by our advances in medicine, whereby we have produced a large population of people over 65 who require more medical care. The positive and desirable aspects of our system of medicine would take quite a while to enumerate—and most of us are very familiar with them, so I will not be-

Presented at the Medical Legislative Conference of the Medical Association of Georgia, April 23, 1961, Macon, Georgia.

labor you with these.

On the other hand, I am going to stress some troubles in which we find ourselves—some problems we are going to have to face and with which we must grapple—in order to convince the American public—and thereby its elected representatives—that our system of medical practice is the kind that will give the best health care to the most people. For if we only look at these problems from the standpoint of what is best for the American physician, we have lost the battle already.

One major problem we really don't like to face or discuss is the fact that the *image* of the American physician is changing—has changed—in the last few years—and that much of this is to our great disadvantage. Now the way I am using the word “image” in connection with doctors is the way our advertising friends use it—to mean something that people think is so—whether it really is or not. *The image of physicians is what people think of physicians—whether it is really true or not.*

The picture of the old family doctor who was well known for his philosophy, his sympathy, and his words of wisdom, although he might have been lacking in deeds to produce a cure, is almost gone. For these attributes he was respected, and rightly so. Now this image of a physician has changed. Originally, medicine was more of an individualist's art; today it has to be practiced as a team effort which includes much ancillary personnel. We have to call upon electronic engineers, chemists, mechanics, and technicians in our work. The image of the physician is changing into one of more scientific knowledge and information. No longer is the physician thought of as a mystic or his healing mystery, but as scientific information is disseminated, the public is more informed. The physician has to keep better informed himself, and he has to keep up to date in treatment, as well as current topics.

I do *not* believe that this image of more scientific knowledge is hurting the general image of the physician, although the “old family doctor” is still a source of nostalgia to many. The public, being more informed, *wants and expects* the latest and best in scientific achievement. No, in my opinion, it is from *other sources* that the detrimental aspects of our image are coming.

One major element is the international humanitarian revolution which is now in progress and which is of a political and socio-economic nature. People are being told that health care is a matter of right, and promises of good health at public expense constitutes one of the most persuasive and obvious issues by which political control can be

attained. People of this country in particular and also of the rest of the world are most interested in their own personal health problems, longevity, and the enjoyment of the fruits of medical research and accordingly a higher standard of medical practice.

Population changes are having more effect on people than is generally realized. Dr. Harrison Brown of California Institute of Technology points out that the population has been growing by approximately 18 per cent per decade, and if this growth continues, within 730 years human beings will be so tightly packed that each of us will be able to own only one square foot of land. We, as “over-stuffed” Americans with our ulcers and gall stones, do not realize that there are more hungry people in the world today than ever before in the history of the human race. It is certainly ironic that the medical profession which has prolonged life is also increasing the problem of over-population in the world, and is now being caught in a web of its own altruistic endeavors, and you and I are being condemned by socialistic individuals who are attempting to regulate your individual rights.

“Individual Physician” Image Changed

The image of the “individual physician” as a member of the *community* has also undergone some unsavory changes. *This* is the image that radiates to the professional people with whom we come in contact, our friends, patients, and others in our environment. Not only do we radiate this image in our daily practice, but we hear the oft-repeated commentary on members of the medical profession that we are fast becoming the nation's chief exponents of the art of “conspicuous consumption”. As Vance Packard's “The Status Seekers” states, in any community the doctors far outnumber the other professions in living in the most expensive residential district, driving the most expensive car, etc. The arguments and defenses of these are many, and certainly in mid-century American doctors are not the only “conspicuous consumers”. However, the public is more prone somehow to condone this “conspicuous consumption” in a family who has made its money selling insurance, real estate, or bricks than, “at the expense of someone else's misfortunes.” Therefore, it behooves us of the medical profession to be extremely careful in this area, and even more so in the control of *lingorrhea* and *mal de graphia*—or the science of saying and writing the wrong thing at the wrong time. These two diseases are much in evidence when the doctor in a group at the country club invokes the new “status symbol” of telling everyone about his profits on the stock market—or writing his congressmen, and this has actually happened, he tells them, “You knuckle-

heads are going about this thing in all the wrong ways. You are all wet and don't know what the score is".

As one recent article states, a doctor's bag contains three things: miracle drugs, nothing under \$10.00 prescriptions, and Sam Snead's volumes on golf. This article continues that to a large group of people the U. S. medical profession is made up of men who are sincere, selfless, loyal and sympathetic. To another group the U. S. medical profession is formed by men who are avaricious, self-seeking, inhuman, lackadaisical, and hypocritical.

Like many American industries today, we have been accused of pricing ourselves out of the market and being unable to meet the competition of the proponents of government medicine. In our own MAG survey this year of mayors, editors, etc., the most often heard complaint against physicians was that our fees are too high. Each of us should realize our stake in the outcome of the current social changes and not be guilty of either neglecting to do our part in combating the forces advocating more federal control or, by actions of our own giving the American people reason to think that federally controlled medical care would be preferable to the kind we practice today.

This brings to mind another survey report, the third by this non-medical individual, in which he states: "This last survey made in early 1961 was the first time that more than half of the group of people said they wanted the government to come into the act more, to set up some kind of program where they would not have to worry about medical bills and ill health." This survey was divided into two groups: one all college graduates, and they were less prejudiced, understood the doctor's position more. The other group with high school or less education regarded the doctor with outright hostility, considered him a high-priced mechanic who fixes their problems with an injection. They disliked his charges, avoided going to him, and are looking for someone or something to solve their fears of high medical cost.

Forces Working Against Us

There are strong forces working against us, particularly in *government and labor*. There are many socialistically inclined organizations in this country and particularly some writers who are helping mold this deleterious image of the physician. These same writers are the first to complain bitterly if the least suggestion is made for censorship of their writings or suppression of the least bit of news.

Ralph W. Gwinn, a former member of Congress, has written: "First, you should know that labor—or rather top officials of organized labor—dominate

Congress; over 175 members of the House have benefited from union contributions, free campaign help, radio, TV time, advertising, extensive publicity, doorbell ringers, etc. Business organizations do none of this. Business as such is unorganized politically and, therefore, impotent."

He continues: "The trouble in Congress is not that we do not know what legislation is needed. We do not have the votes to get it passed. The answer is that each business and professional man see that men are elected committed to restore constitutional government and law and order. It is up to you and others who think as you do to get your committees formed and members of Congress elected who think as you do."

British Viewpoint

Dr. E. Gray-Turner, Under-Secretary of the British Medical Association, stated he felt it was a great mistake to allow the government or any other controlling body to acquire a monopoly or a near monopoly on medical service. This places the doctor at the mercy of forces which may have no interest in or sympathy for the personal and confidential relationship. Dr. O. O. Peterson, of the Division of Medicine and Public Health of the Rockefeller Foundation, after studying the English national health system put it this way: "Unlike so many things produced in Great Britain now, it (the English system) is not for export."

Let's ask ourselves a few questions: Is your heritage worth maintaining? Do you want to lose it? Do you want to give it away by default? Are the socialists correct? Do we actually need drastic changes in the image of the physician or in medical practice as we have it today? If so, what are these needed changes? Is there really an aged problem? Is there a lack of proper care for patients? Are they getting adequate medical care? First and foremost, are you doing your part? Have you taken your stand?

If you feel that your heritage is worth preserving, it is not up to me, it is not up to organized medicine, it is up to you, the practicing physician, the individual American, to carry it to the people in your area and let them pass the word on to your elected officials, the one who represents you in government as well as organized medicine. Plato 2000 years ago said that one of the penalties for refusing to participate in politics is that you end up being governed by your inferiors. Doctors have the brains, the knowledge, the tools with which to work out their own salvation at a time of crisis. They can do it brilliantly if they so desire and if each person would accept his local responsibility.

The nation's health is the concern of industry and government in that production and consumption

affects the national strength. People are being told that health care is a matter of right. Doctors must take the initiative in instigating whatever is necessary to provide proper health care; if they do not,

someone else will. As I see it, the present legislation is the foot in the door for socialization of medicine. Your heritage is that you are a free member of a free profession in a free society. If you want to save it, it is your own personal responsibility, but—I warn you—it is NOW OR NEVER.

Nahunta Attracts a Doctor

NAHUNTA IS A TOWN of 2,991 population in Brantley County Georgia. Over two years ago the local Lions Club decided that a physician was needed in the county. A mass meeting was called at the courthouse to determine if the community was interested in constructing a medical building to attract a doctor to their county. The reaction was sufficiently strong to encourage the Lions to write the Sears Roebuck Foundation for help. The Foundation is designed to assist small communities obtain doctors and facilities where they are needed. The Foundation forwarded a questionnaire to the Nahunta group. From the results of the survey the Foundation concluded that Brantley County needed a doctor and could support one. A group of Brantley County citizens formed a corporation for the purpose of selling bonds. From this group were appointed three committees: 1) the finance committee, 2) the building committee, and 3) the doctor procurement committee.

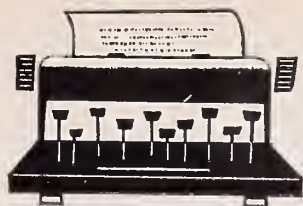
The finance committee began by appointing members of the Lions and Jaycees as bond salesmen. The building committee worked with the Foundation on plans for the new medical center. The Foundation sent several sets of plans that were modern and simple in design so as to avoid unnecessary expense. The corporation chose the floor plan that would accommodate two doctors adequately. The site selected for the Center is on Highway 84, east of Nahunta on land donated by the Brunswick Pulp and Paper Company. Contracts were let for bids and construction begun. The doctor procurement committee interviewed doctors and selected Jesse Lee Walker, M.D., a native of Thomasville, Georgia. He had previously practiced medicine in Wise, Virginia and Buford and Clarkesville, Georgia. Dr. Walker graduated from Emory University School of Medicine and served in the medical corps during World War II

The Brantley County Medical Center was dedicated on June 25, 1961. Mr. Pete J. Gibson, president of the Brantley County Medical Center, Inc., served as master of ceremonies. He praised the community for its work and determined effort to make their dream a reality. He lauded the Lions Club, the Home Demonstration Clubs of Brantley County, the Jaycees, the Nahunta Junior Woman's Club, the county commissioners, the Brunswick Pulp and Paper Company, the American Medical Association, the Medical Association of Georgia, and the Sears Roebuck Foundation.

Dr. Joseph Mercer of Brunswick represented the Medical Association of Georgia at the exercises. Mr. Wallace E. Jernigan of Homerville, representing Governor Vandiver, was the main speaker. Dr. Walker and Mr. Jernigan participated in a ribbon cutting ceremony and visitors were invited to an open house at the Center.

The 2,200 square foot structure is one story, completely air-conditioned, has four examining rooms, two consultation rooms, an x-ray room, an emergency room, five bathrooms, large waiting rooms, and adequate storage rooms. Medical equipment was furnished by Dr. Walker who will lease the building.

The Walkers arrived in Nahunta on June 4, and moved into a home on Highway 84. During Dr. Walker's first weeks of practice he saw 700 separate patients. Dr. Walker has stated that he is "mighty pleased" to return to Georgia after an absence of three years. He has entered into Nahunta's social and civic activities. He has affiliated with the Nahunta Lions Club and the Walker family attends the Nahunta Methodist Church. Dr. Walker is a member of the Ware County Medical Society, the Medical Association of Georgia, the American Medical Association, the Southern Medical Association, the Georgia Academy of General Practice, and the American Academy of General Practice.



editorials

Pyelonephritis

RICH RESEARCH IN THE FIELD of pyelonephritis is about to reward the patient investigator after many years of seeming indifference and neglect. Pyelonephritis, long held to be simply the result of obstruction somewhere along the urinary tract and the responsibility primarily of the genito-urinary surgeon, is now receiving the attention that the seriousness of the disease warrants.

Exciting new concepts of renal architecture and physiology are replacing previously held convictions, for example the unit-nephron theory of independent function. The unit-nephron is yielding to a revolutionary physical idea called renal "counter-current." The thin segment called Henle's loop, the site at which urine is concentrated, is viewed as a hairpin in which there is an osmotic gradient that reaches its maximum at the bend. There is an osmotic stratification in the medulla, pressure being minimum at the cortex, greatest at the pelvis. Disease of the medulla of the kidney, especially of the collecting ducts, may affect the kidneys' ability to concentrate urine while other renal function is hardly disrupted.

The kidney is known to be unable to protect itself against the colon bacillus once the organism has gained admission via either ascending or hematogenous routes. The normal antibacterial mechanism of the urinary tract as well as other body tissues is dependent upon the effectiveness of the fourth component of complement in the serum. The normal kidney, in one of the oddest vagaries of nature, permits bacterial multiplication by way of ammonia's inactivation of complement. While ammonia formation varies widely, the more ammonia produced the

greater anti-complementary action of the kidney, and the more susceptible the medulla becomes to the coliform bacillus.

Since the diseased kidney is unable to concentrate efficiently urea is not available in bacteriacidal concentrations. It has been suggested that intravenous four per cent urea may enhance this host-defense deficit. Host-defense mechanisms of the ammonia-anti-complementary type must be considered if therapy is to be effective. Acidification of urine or water diuresis may theoretically be effective anti-bacterial measures but they apparently do little to enhance host-defense mechanisms. One destroys complement, the other reduces the amount of urea available. Renal cortical blood flow is ten times greater than medulla blood flow. Therapy directed against infection in the medulla must be geared to the blood flow differential.

Immunological studies show that animals which have recovered from an acute bacterial infection fail to develop pyelonephritis the second time when subjected to a similar substance and trauma using the same bacterial species. Isn't it likely that the same situation applies to human kidney infections which may explain why most human renal infections are self-limited even without antibiotic treatment. The important question is what happens to the immune responses in those individuals who have recurrent or persistent pyelonephritis. It seems likely that these chronic illnesses are due to other immunological factors at work.

Catheterization of the female urethra is a useful technique when properly performed. Abuses have

led to rather bizarre reactions in which all pyelonephritis is said to result from catheterization, hence no one should be catheterized. In spite of these warnings the intelligent use of the catheter has an important place in medicine and probably plays a minor role in the frequency of pyelonephritis. As a matter of fact the bacterial flora of the urethra is free of the coliform bacillus.

Despite two decades of intensive antibacterial measures, the incidence of pyelonephritis remains the same. Perhaps misuse of antibiotics and chemotherapeutic agents as well as the excessive use of phenacetin and related drugs have contributed to the increasing numbers of cases of pyelonephritis. But many questions remain unanswered. What causes the death of the white blood cells that are poured out by the pyelonephritic? Why does proteus in particular and other coliform organisms have the ability to reduce the bactericidal power of renal tissue? Do these organisms grow intracellularly?

Some answers are available. The renal tubular cell is rich in glutaminase activity. An increase in glutaminase activity causes an excessive production of ammonia. Cells die after several hours exposure to

a pH of eight brought about by the ammonia released. It is possible that the formation of magnesium-ammonium-phosphate crystals is brought about by the action of the proteus on intracellular metabolism. The administration of ammonium chloride or other acidifying agents as well as certain types of diuretics that result in low potassium levels increases glutaminase activity and results in cellular destruction comparable to that produced by the proteus organism.

In summary, an old disease is receiving new attention of investigators from various disciplines. Research laboratories and clinical investigators have uncovered a wealth of information which substantiates in part previous concepts of renal physiology yet there is much which sheds light bright enough to illuminate new avenues of therapy. An understanding of the results of these investigators is essential to satisfactory, long-term clinical results.

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MAG Voice Is Heard In Congress

WITH THE 87TH CONGRESS at the halfway mark, Representative Cecil King's legislative monstrosity, HR 4222, is resting uneasily in the Ways and Means Committee of the House of Representatives.

On February 13th of this year, Congressman King dropped his now infamous bill into the House hopper and the wheels, both legislative and medical, have been grinding away ever since.

The introduction of this bill by the gentleman from California came as no great surprise to the Medical Association of Georgia. It had been anticipated during the early weeks of the present Administration.

The Council of MAG and its Executive Committee, recognizing the dangers inherent in the King Bill, sought to formulate and execute plans to present a solid and determined front of resistance to this bill.

Initially, a broad information and education program was undertaken to inform businessmen, opinion leaders and the general public as to the provi-

sions and the danger areas in the King Bill. To activate this I & E Program, a series of legislative breakfasts were scheduled and held in various locations around the state. Medical and lay speakers were made available for civic meetings and informational material was supplied to clubs and trade and professional associations upon request.

The Council was, from the beginning, cognizant of the roll that MAG members could and would have to play in this legislative fight. To insure that its membership was fully informed to the end that they would each become a more forceful and articulate weapon of defense, Council authorized a day-long legislative conference in Macon on April 23rd.

In the late spring, rumors were beginning to circulate that a move would be made in the Senate to amend an unrelated social security bill by attaching to it the language of the King bill. The social security measure in question had already passed the House and the effect of such a maneuver would have been to bypass the Ways and Means Committee

which has original jurisdiction in all money raising matters.

To head off this move in the Senate, the tax writing House Ways and Means Committee, justifiably jealous of its Constitutional prerogative, announced that it would schedule hearings on the King bill as its next order of business.

MAG immediately requested time to present a statement before the Committee in opposition to this bill and notified each of its constituent County Medical Societies of their opportunity to make similar requests.

The Committee's finalized plans for these hearings indicated that time would not permit the County Societies to make a personal appearance before the Committee. However, in lieu of this, the Committee would accept written statements to be included in the transcript of the hearings and several County Societies availed themselves of the opportunity to register their protests by this means.

With the hearings set for July 24th through August 4th, Council authorized and approved a 5,000 word, 30 minute statement to be presented by the Association's Secretary to the Ways and Means

Committee. A synopsis of this statement appears on Page 508 of this issue of the *Journal*.

At this writing, no official statement has been made by the Committee or its Chairman, as to what disposition will be made of the bill. Whether the Committee feels that this measure has sufficient merit to bring it to the floor of the House, or whether it will die in Committee, is something known only by the members of the Ways and Means Committee.

It appears that the bill has at least a 50-50 chance of being reported out of the Committee. In the event that it is, it is reasonably certain that dissenting minority views will be filed at the same time by those members of the Committee who share MAG's thoughts on HR 4222.

The next ten months will be critical, indeed, for the medical profession. Nothing short of an all-out effort on the part of every doctor and every layman concerned over the future of American medicine, will be sufficient to stem the tide of this first step towards the socialization of American medical practice.

It is your profession. It is your fight. And, this fight will be won for now or lost for all time during the next ten months.

Teenage Smoking

AFTER CONSIDERING THE EDUCATIONAL film strip from The American Cancer Society, "To Smoke or Not To Smoke" it was felt that these comments could be directed to teenagers who are developing this habit. It is one difficult to give up at best—and after a person has been smoking for many years it becomes even more so. These comments, therefore, are directed to the neophyte or young smoker.

Lung cancer is the chief cause of cancer death in men. It has increased eightfold in 20 years and this increase is the most rapid reported for a non-infectious disease. It is difficult to diagnose cancer of the lung in time for cure. Despite intensive educational programs, only about five per cent of all cases are being saved today.

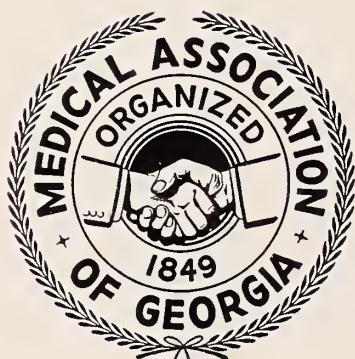
Do cigarettes cause lung cancer? Many scientists who have studied the problem became convinced that cigarette smoking was a cause of lung cancer. The evidence indicated that the more cigarettes a person smokes, the more likely he is to develop this disease. This interpretation of the evidence was then challenged by some scientists. They maintained that no cause and effect relationship has been proved; however, some important developments have occurred in the last several years. A series of recent events suggest that the world of medicine and science

is making up its mind on this important subject. In the United States, an Independent Study Group on Smoking and Health, composed of seven scientists and organized in 1956 to review all the evidence, published its report. The sponsors were the U. S. Government's National Cancer Institute and the National Heart Institute, and the American Cancer Society and the American Heart Association, the latter both volunteer health agencies. The most important conclusions of the scientists was that the sum total of scientific evidence established beyond a reasonable doubt that cigarette smoking is a causative factor in the rapidly increasing incidence of lung cancer.

It is estimated that a man who smokes two packages of cigarettes a day has one chance in ten of developing lung cancer while a non-smoker has one chance in 270. Studies indicate that death from several other sites of cancer and from coronary heart disease were far higher among cigarette smokers than non-smokers. In the American Cancer Society Study, heavy cigarette smokers have about the same death rate as non-smokers who were seven or eight years older. No one can predict what will happen to an individual, but in general those who smoke less live longer.

1962 Annual Session

May 6-9, 1962—Savannah, Georgia



Last Call for Scientific Papers

All titles must be submitted to the
respective program chairmen listed
below before November 1, 1961.

ANESTHESIOLOGY

R. L. Stone, M.D.
5737 Colonial Drive, Savannah

CHEST

John L. Elliott, M.D.
212 E. Huntingdon Street, Savannah
J. L. Alexander, M.D.
104 E. Gwinnett Street, Savannah

DERMATOLOGY

Vincent J. Cirincione, M.D.
800 Abercorn Street, Savannah

DIABETES

Jules Victor, M.D.
5 Medical Arts Center, Savannah

GENERAL PRACTICE

T. A. Peterson, M.D.
11 W. Jones Street, Savannah

MEDICINE

Fenwick Nichols, M.D.
12 Medical Arts Center, Savannah

OBSTETRICS AND GYNECOLOGY

Henry C. Frech, M.D.
2 Medical Arts Center, Savannah

OPHTHALMOLOGY AND OTOLARYNGOLOGY

W. W. Buckhaults, M.D.
905 Abercorn Street, Savannah

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T. A. Amburgey, M.D.
8 Medical Arts Center, Savannah

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H. L. Howard, M.D.
Memorial Hospital, Savannah

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Milton Mazo, M.D.
4 Medical Arts Center, Savannah

PSYCHIATRY

A. H. Center, M.D.
10 Medical Arts Center, Savannah

RADIOLOGY

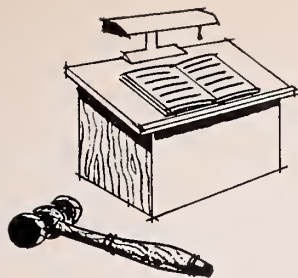
David Robinson, M.D.
P. O. Box 394, Savannah

SURGERY

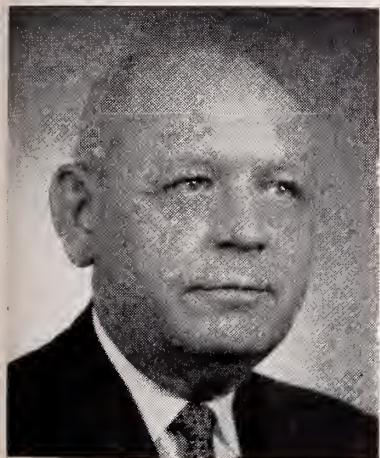
J. R. Winburn, Jr., M.D.
24 E. Liberty Street, Savannah

UROLOGY

Irving Victor, M.D.
228 E. Huntingdon Street, Savannah



president's letter



FRED H. SIMONTON, M.D.

LET'S KEEP MEDICAL DISCIPLINE IN THE FAMILY

OF ALL THE PROBLEMS CONFRONTING the medical profession, few are more perplexing or frustrating than the old problem of medical discipline, or what to do about the delinquent physician.

I am not referring to that infinitesimally small number of practitioners whose conduct makes them the subject of a law suit. The law is well defined and quite adequate to care for itself. My remarks address themselves to that equally small group who live and practice medicine within the law but who are guilty of breeches of medical ethics or who practice legal but bad medicine.

Delinquency in the context that I use the term is much like sin. Everybody is against it, but we are all hard pressed to know what to do about it. However, we can't ignore the problem and expect it to go away. During these troubled times when the medical profession has been placed under a public microscope and scrutinized as never before, it ill-behooves us to permit a continuation of any medical practice, be it legal or not, that does not reflect credit on the profession.

The Medical Disciplinary Committee of the American Medical Association has made an exhaustive study of this matter. In its recent report to the Board of Trustees the Committee made several recommendations designed to shore up those

areas most demanding immediate attention. Among other suggestions made, the Committee strongly recommended that:

Medical Schools should develop and present to their students a course in ethics and medico-economic principles.

State Boards of Medical Examiners should include questions on ethics and socio-economic principles in all examinations for licensure. In addition they should, prior to issuing any license to practice medicine, examine all the available records at AMA, the Federation of State Medical Boards, and every state medical board, to uncover any disparaging remarks against the character of any applicant.

State Medical Associations should become actively concerned with the disciplinary programs of component societies, develop indoctrination courses for new members, continue to develop active and alert grievance committees, utilize grievance committees as "grand juries" to obviate the necessity of an individual member having to complain against a fellow member, and, should amend their bylaws to permit state associations to take necessary action when local societies fail to act.

The Committee on Medical Discipline has performed a much needed service in pointing up the deficiencies attending the overall problem of med-

PRESIDENT'S LETTER / Continued

ical discipline. If we are to retain our traditional right to police our own ranks, then it is extremely important that we recognize the shortcomings of the system and move to mend our medical fences. We must demonstrate that we not only have the will to do the job, but that we possess the machinery to get the job done.

Discipline, no matter how slight or how severe, is essentially a matter for local determination. I would, however, recommend to any county society having a discipline problem which it cannot properly and fairly adjudicate, that such problem be referred to the MAG Board on Professional Conduct. In making this recommendation, permit me to emphasize that primary jurisdiction resides with the county society which has the problem. Responsibility in this matter cannot be abdicated unless the problem is of such a nature as to dictate the advisability of this course of action.

The problem of ethics and medical discipline cannot be easily solved. It can, however, be simply stated. As with any profession, medicine has in its ranks a small number of practitioners who

play loose with the cannons of our profession. If permitted to go unchecked, their conduct will tarnish the good work being done by the great majority of dedicated, ethical physicians.

Our responsibility in the field of ethics is unequivocal. Either we shall rid the profession of marginal practitioners and chronic offenders or we run the risk of having the job done by a third party outside the medical profession. *This, no one wants.*

I cannot over-emphasize the need for diligent and painstaking work on the part of local and statewide committees charged with the responsibility of weeding out those who threaten the public's confidence in the medical profession. This can be done and must be done, not only for the protection of the profession, but most importantly for the protection of the public.



President, Medical Association of Georgia

Georgia to Begin Hospital Care Program for Indigent Aged January 1

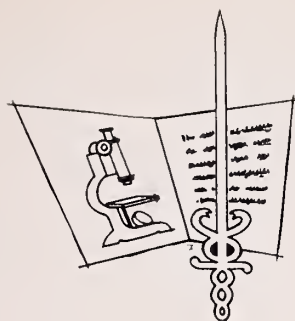
Georgia will participate in the federal Kerr-Mills program, beginning January 1, 1962, to provide hospital and nursing home care to approximately 100,000 of its citizens of age 65 or over. The eligible group will be those who are on the Old Age Assistance rolls of the State Welfare Department.

As announced on August 8 by Governor Vandiver, the State will put \$1,440,000 into such a program. Federal matching monies will bring the total to \$7,200,000 per year available for hospital and nursing home care. Georgia's portion of the program budget will not come from the State's surplus funds. It will be derived from adjustments in the present overall budget of the Welfare Department. This arrangement promises a reasonable permanence to the program once it is set up.

The Welfare Department is expected to ask the State Health Department to administer the aged care program through a contractual arrangement. Authority to do this is provided in the enabling act

passed by the last General Assembly. Under such an arrangement the Welfare Department would retain two basic functions: (1) certify financial eligibility of cases; and (2) disburse payments to hospitals and nursing homes. All other programming and administration would be through the Health Department. (Eligibility of cases would be relatively simple as it would be limited to persons already certified as indigent and receiving monthly OAA checks from the Welfare Department.)

Rules and regulations are currently being worked out. It is anticipated that paid hospitalization will be limited to 10 days per admission and 30 days total per year. The Third Party Payments Committee of Georgia Hospital Association meets on August 23 with Dr. John H. Venable, Director of the Georgia Dept. of Public Health, to discuss implementation of the program. The reimbursement rate to hospitals is expected to be on a per diem basis as computed under Georgia's new hospital reimbursable cost form.



cancer page

THE IMPORTANCE OF NUCLEAR MEDICINE TO CANCER CONTROL

Enoch Callaway, M.D., *LaGrange*

WITH INCREASING KNOWLEDGE of the properties and activities of radioactive isotopes and also the constant improvements being made in instrumentation for their use and measurements it becomes more apparent that they will assume a constantly increasing importance in cancer control. The potentialities of these substances both as sources of therapeutic radiation and as diagnostic indicators are now only in a very early phase of development. The future holds promises of steady and valuable advancement.

The use of radioiodine¹³¹ in the diagnosis and treatment of certain functional carcinomas of the thyroid is one of the oldest and best established procedures. This substance is of extreme value in locating and treating metastatic implants from these cancers.

Radiophosphorus³² has proven so valuable in the treatment of polycythemia vera that it is considered by many practitioners to be the treatment of choice in this disease.

The use of various and sundry isotopes particularly colloidal gold by infiltration into the cancers or by injection into the pleural or peritoneal cavities may have some benefits not obtained by a similar use of Mustargen, Thio-Tepa or other alkylating agents. At the present time it has not been shown that the Isotopes have sufficient advantage to justify their expense and the additional difficulty

of their use. The intra-arterial use of Yttrium⁹⁰ made into specific sized particles which are captured in the capillary bed as described by Dr. Edgar Grady and associates, may be a step in the right direction.

At the present time it is not apparent to me that implanted Cobalt⁶⁰ or Iridium¹⁹² have any advantages over the use of radium needles or gold radom implants.

Cesium¹³⁷ with about 665 KEV equivalent and Cobalt⁶⁰ with about 1250 KEV equivalent have proven to be excellent and economical replacements for deep therapy x-ray machines. When one considers that at five cm in tissue 200 KV x-ray with .5 mm copper filter has an effective energy of only about 75 KEV and considers that these gamma ray generating isotopes have an almost homogeneous spectrum, their relative effectiveness and value becomes more apparent.

In cancer research the ability to tag certain compounds with radioactive elements and thereby being able to actually trace their progress and activity in the body opens a field of tremendous possibilities. There is also the possibility that some of the cancer chemotherapeutic agents which are known to have selective uptake by cancer cells can have added radioactive elements which will prove of value in diagnosis and may possibly be made to have sufficient additional cancer cytotoxic activity to ma-

terially enhance their cancer destroying ability.

There are at present many valuable procedures using radioisotopes for diagnosis of cancers that cannot be easily reached for cytological or tissue studies. By the use of a neutron activator system practically any compound can be made sufficiently radioactive to study its fate in the body. This opens up fabulous and fascinating opportunities for a wide variety of investigations and may possibly aid

in the development of extremely useful and economical methods of mass cancer survey. This also offers the hope that the selective absorption of these compounds after they have been made radioactive may lead to ever increasing efficiency of cancer diagnosis through the easy detection of the radioactive substances.

It would appear that the future holds wide prospects for the increasing usefulness of nuclear medicine in cancer control.

Approved by Professional Educational Committee, Georgia Division, ACS.

A.M.A. ANSWERS RIBICOFF'S CHARGES

THE AMERICAN MEDICAL ASSOCIATION branded as untrue certain statements by Abraham Ribicoff, Secretary of Health, Education and Welfare, concerning the Administration's legislative proposal to provide medical care for the aged under Social Security.

Dr. F. J. L. Blasingame, A.M.A. executive vice president, presented a point-by-point rebuttal in a letter to the more than 500 editors from throughout the country after Ribicoff addressed the annual meeting of the American Society of Newspaper Editors in Washington.

Dr. Edward R. Annis, Miami surgeon representing the A.M.A., accused Ribicoff of misrepresenting the role of doctors under the administration proposal. Dr. Annis answered Ribicoff on a radio-television program with Sen. Kenneth B. Keating (R., N.Y.) which was taped in Washington. Ribicoff had made the misrepresentation on an earlier Keating program.

Dr. Blasingame said Ribicoff's statement before the editors that physicians are not included in the administration proposal, the King bill, "simply is not true." The A.M.A. official pointed out that the bill includes interns and residents in teaching hospitals as well as pathologists, radiologists, phychiatrists and anesthesiologists working in hospitals or serving hospitals' outpatient clinics.

"Mr. Ribicoff further claims that the King bill provides free choice of hospital physicians," Dr. Blasingame said. "The fact is only hospitals signing contracts with the federal government would be available to patients. If the only hospital in a community was not approved by the Secretary of HEW, patients in that community would be forced to seek hospitalization in some other city. That would not afford free choice of hospital. If the patient's physician was not on the staff of the other hospital, the patient would be denied free choice of physician."

Dr. Blasingame also disputed Ribicoff's contention that the King bill is not socialized medicine.

"By common definition, any scheme which calls for a system of compulsory health care which is adminis-

tered, financed, and controlled by the federal government is socialized medicine for that segment of the population it serves."

Rep. Walter H. Judd (R., Minn.), who is a physician, was quoted as one of a number of House and Senate members who agree with the A.M.A.: "The public has been led to believe that they can get government financing without government control and ultimate government operation of medical services. It is naive for anyone to believe that Congress will take the people's money away from them through taxes and then allow the money to be spent by someone else without the Congress maintaining its own firm control."

Pointing out that the nation's physicians always have been in favor of medical care for all regardless of ability to pay, Dr. Blasingame said:

"It seems strange to us that Mr. Ribicoff continues to lobby for the King bill while completely ignoring the Kerr-Mills law, passed by Congress last year with strong support by the nation's physicians.

"The Kerr-Mills Law enables the state to guarantee to every aged American who needs help the health care he requires. And the states are implementing the law with unprecedented swiftness."

Dr. Annis pointed out on the radio-television program that "doctors would work for the government by working for the hospitals under contract to the government." He said those doctors would work "under rules, regulations and controls prescribed and laid down" by the HEW.





THE POST-MYOCARDIAL-INFARCTION SYNDROME?

Luther Fortson, M.D., *Marietta*

SINCE 1956 Dressler¹⁻³ has written extensively of a complication of myocardial infarction, which is characterized by fever; chest pain of a pleuritic nature; evidence of pericarditis, pleurisy, and pneumonitis; and a tendency to recurrences. Later, he described hemorrhagic pericarditis in association². This complication he referred to as "a post-myocardial-infarction syndrome", and its similarity to the post-commissurotomy syndrome and idiopathic recurrent pericarditis was noted. Since the original description other writers in various parts of the world have reported cases.

Dressler estimates that this complication occurs in three to four per cent of cases of acute myocardial infarction; he feels that it is probably a sensitization phenomenon related to an antigen produced by myocardial necrosis.

This syndrome is characterized by pericarditis appearing between the second and eleventh weeks of illness, lasting several days to several weeks, commonly accompanied by pericardial effusion (sometimes hemorrhagic); often accompanied by pleurisy and pneumonitis, and practically always manifested by pain which varies with respiration and body position. Fever, moderate leukocytosis and high sedimentation rate are noted to be characteristic; electrocardiographic changes compatible with pericarditis are described in about half the cases. Serial chest X-rays may demonstrate rapid changes in the cardiac silhouette.

The benign prognosis of this complication is

stressed, but anticoagulant therapy is contraindicated. Corticosteroids appear to provide immediate gratifying relief of pain and fever, but relapses may occur on withdrawal of the drug.

Dressler states that the syndrome can be distinguished from extension of the myocardial infarction by the pleuropericardial character of the pain and by the electrocardiogram which fails to reveal evidence of extension; and from pulmonary embolism by the finding of pericarditis.

It is interesting to note, however, that an adjective has been altered and this is now referred to as "The post-myocardial-infarction syndrome." Familiarity may breed carelessness instead of contempt and there has perhaps been a tendency to aggregate other complications of myocardial infarction under this label. Surely there must be a post-myocardial-infection syndrome which behaves as a sensitivity phenomenon and responds to steroids; but surely this must be quite rare, at least in Georgia.

The complication of lingering chest wall soreness and tenderness over the precordium, with sticking pain associated with motion of the chest wall, must be much more common. This "Anterior Chest Wall Syndrome" is a nuisance to the patient who is aware of its true nature, and it can be a terror to the unwarned. This musculoskeletal pain must be related to peri-arthritis of the shoulder and the shoulder-hand syndrome—another complication of infarction which affected at least 15 per cent of

cases a few years ago. Now, with early ambulation and efforts to prevent atrophy of disuse, it is a rarity.⁴

The most distressing and disabling of the post-myocardial-infarction complications must be the depression, sometimes profound, which so frequently descends upon the coronary victim during his period of inactivity. Characteristically this appears at about the middle of the second week of illness, when the patient comes to grips with the realization that his mode of living, his usefulness to his family, even his very survival are threatened by his atherosclerotic plaques. Expectant treatment by early and complete discussion of the nature of the disease, explanation of the capacity of the heart to heal, and a positive and optimistic approach in returning the patient to a state of self-sufficiency all serve to minimize the depressive reaction. Simple explanation beforehand that a period of "the blues"

is almost to be expected, and that it, too, will pass, seems to be the most effective preventive measure.

Awareness of the existence of the syndrome as described by Dressler could spare the physician and patient much needless apprehension, but criteria for diagnosis strict enough to recognize the cases of pulmonary embolism and extension of infarction which surely do occur, must be adhered to. Precision of diagnosis in distinguishing between the many possible complications of infarction is the first and most important step in returning the patient to his maximal functional capacity.

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Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

Georgia Doctor Attends Seminar on Nuclear Energy

Dr. John T. Godwin, member of the Governor's Georgia Nuclear Advisory Commission and Head, Biomedical Facility, Georgia Tech Reactor Research Project, recently attended the Southwest Seminar on Management and Uses of Nuclear Energy in Hot Springs, Arkansas. This seminar was sponsored by Arkansas, Louisiana, Mississippi, Oklahoma and Texas in cooperation with the Atomic Energy Commission, the Defense Department, the National Aeronautics and Space Administration and the Regional Advisory Council on Nuclear Energy.

Representatives from the remaining 16 Southern States composing the Southern Interstate Nuclear Compact were present.

The purpose of the meeting was to bring greater understanding to businessmen, educators, legislators, form leaders, science students and citizens at large, regarding the many applications of nuclear energy to modern living, and project its application, problems, and potentials.

The Seminar chairman was Mr. Winthrop Rockefeller. Among the many distinguished speakers were Dr. Leland J. Haworth, Commissioner, Atomic

Energy Commission, Dr. Wernher von Braun, Director of the George C. Marshall Space Flight Center, NASA, Huntsville, Alabama, and Dr. Edward L. Teller, Professor of Physics at Large, University of California.

This meeting was of particular interest to Georgians in view of the developing program at Georgia Tech with the construction of a Research Nuclear Reactor which will be completed in the fall of 1962.

Of great interest is the application of nuclear energy in the rapidly developing space program, as discussed by Dr. von Braun. This is significant and relates nicely to the recent designation by Governor Vandiver of a Georgia Aeronautics and Space Administration.

Georgia is developing a suitable environment for significant progress in the areas of Space and nuclear energy. The development of interests by young people in these fields and the training of these people in the technological areas required appears to be one of our greatest needs in order to meet the challenge of the exploration of space.



THE CLINICAL ORIENTATION OF A CHILD GUIDANCE CLINIC

George H. Preston, M.D., *Atlanta*

CLINICALLY, a Child Guidance Clinic is oriented around certain basic assumptions. The first assumption is that no child functions in a vacuum. A child is always doing something about something at a specific time in his development and in a very special setting.

The setting within which the child's behavior occurs includes as its center, in addition to such factors as home, school, siblings, and peers, the equally concrete matter of parents' attitudes toward each other and toward the child. This point of view assumes that paternal tension and discord, conflict as to basic regulations, seduction or rejection by either parent, contrasting ambitions or mutual hostility, can produce and prolong unacceptable behavior patterns in children.

That a parallel between this assumption and the behavior of emotionally disturbed patients on a hospital ward exists is demonstrated by Stanton and Schwarz in "The Mental Hospital".¹ They showed that undesirable behavior in patients could develop and continue if conflicting points of view and differing goals grew up between the ward administrator and the chief nurse. Modification of the patient's behavior on the ward tended to follow readjustment of the relationships between these two authoritative figures. A Child Guidance Clinic staff assumes that similar conditions exist within a family.

A second assumption which influences practice in a Child Guidance Clinic is that young children tend toward the resumption of socially acceptable behavior if the noxious factors in their immediate sit-

uation can be removed. In spite of such obvious exceptions as organic damage, certain early psychotic conditions, prolonged parental rejection and neglect, lack of regulation and control carried to an excess, a Child Guidance Clinic assumes that if locally unsatisfactory domestic and parental situations are modified there can be reasonable expectation of improvement in the clinical picture. Such environmental modification needs to be supplemented in certain cases by direct therapy with the child, but it must always be borne in mind that therapy with young children stands little chance of success if the child continues to live in a pathogenic setting.

In the third place, a Child Guidance Clinic assumes that there is no "General Issue Child". Each child patient is looked upon as a unique individual possessing a specific biological makeup and highly personal anatomical and physiological equipment. He is known to have suffered from accidents and illnesses occurring at more or less specific stages in the course of his development and to have been exposed, again at more or less critical periods, to many beneficial and many detrimental attitudes and influences.

For information sufficient to satisfy the demands of these basic assumptions, a Child Guidance Clinic calls upon four related disciplines. Work must begin on a solid medical background, including an investigation of the intactness and functioning of the central nervous system as well as the organs of special sense. Because a Child Guidance Clinic works with living humans, sound medical work must

be provided either within the Clinic organization, by the patient's private pediatrician, or by other community facilities.

To this foundation, the psychiatric social worker, the clinical psychologist, and the psychiatrist each add their particular contributions so that a complete picture of the child, his development, his experiences, his feelings and beliefs, and the attitudes of the significant individuals with whom he lives can be developed and presented to the Clinic Staff.

At this point the orientation of a Child Guidance Clinic differs most widely from that held by a single practitioner in any one of the associated fields. In the Child Guidance Clinic no single discipline produces a diagnosis. Each contributes its share of information and professional skill to a dynamic, etiological formulation of the child's problem. Such a diagnosis is not expressed in a single word but is more commonly a brief summary of the factors which contribute to the child's behavior.

The therapeutic advantage which a Child Guidance Clinic possesses becomes evident after the four-disciplined etiological formulation has been presented. Each factor is found to contribute to the next and the interaction of all factors supports the continuation of symptomatology. The problem then presented to the therapeutic group is to determine which factor is most amenable to modification—which particular facet of this pathogenic circle represents the therapeutic point of election.

Under such circumstances, a Child Guidance Clinic may work exclusively with a child patient, with a child and his parents simultaneously, with the child's school, with the public health nurse, or with the pediatrician who has contact with the child. It is the opportunity for such diverse facets of treatment that gives a Child Guidance Clinic its unique clinical orientation.

REFERENCE

1. "The Mental Hospital," Stanton and Schwarz, Basic Books, 1954.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

Flu Cycle May Hit U.S.A. This Year

Dr. Luther L. Terry, Surgeon General of the Public Health Service, reported today that an upswing in the influenza cycle is likely to hit this country during the fall and winter.

He recommended immediate vaccinations for persons in the three groups which accounted for most of the 86,000 flu-triggered deaths between September, 1957, and March, 1960. These groups are: Persons with heart disease, pulmonary disease, diabetes and other chronic illnesses; persons over 65; and pregnant women.

"We are probably due for some Asian flu outbreaks, since they come in two to three year cycles, and we are overdue for Type B flu outbreaks which come in four to six year cycles," Dr. Terry said. "Asian flu has been dormant here since March, 1960 and it has been more than six years since we had much Type B flu in this country."

Both types of flu were prevalent in other countries in the 1960-61 flu season, notably in England where flu was the direct cause of more than 1,000 deaths and the indirect cause of several more thou-

sands. In 1951, when England had a similar epidemic, it reached this country the following year, Dr. Terry noted.

The Public Health Service is alerting physicians and health officers, he said, and the Bureau of Public Assistance, another unit of the Department of Health, Education, and Welfare, is urging States welfare agencies to include flu immunizations in medical care provided under public assistance programs.

"All persons in the risk groups should get a flu shot right now," Dr. Terry said. "People who have not had any previous shots should have a second injection in two months."

He emphasized that once flu strikes a community, it is too late to protect the high risk groups. Vaccination now, ahead of the flu season, is the only safeguard.

"The most tragic aspect of flu," said Dr. Terry, "is that it is fatal to so many people who, in spite of their age or chronic impairments, could otherwise enjoy many more years of relatively good health."



physician's bookshelf

BOOKS RECEIVED

Rubin, Eli H., M.D. and Rubin, Morris, M.D., **THORACIC DISEASES**, W. B. Saunders Co., Philadelphia, pp. 968, \$25.00.

Levinsohn, Florence and Kelly, G. Lombard, M.D., **WHAT TEEN-AGERS WANT TO KNOW**, Budlong Press Co., Chicago, 1961, pp. 89, \$1.50.

Gross, Ludwik, M.D., **ONCOGENIC VIRUSES**, Pergamon Press, New York City, 1961, pp. 393, \$12.00.

MAYO CLINIC DIET MANUAL, third edition, W. B. Saunders Co., Philadelphia, 1961, pp. 222, \$5.50.

Krants, John C., Jr. and Carr, C. Jeleg, **PHARMACOLOGICAL PRINCIPLES OF MEDICAL PRACTICE**, The William Wilkins Company, Baltimore, Md., 1961, pp. 1498, \$15.00.

Batchelor, R. C. L. and Murrell, Marjorie, **A SHORT MANUAL OF VENEREAL DISEASES AND TREPONEMATOSIS**, The Williams and Wilkins Co., Baltimore, Md., 1961, pp. 316, \$6.00.

de Reuck, A. V. S. and O'Connor, Maeve, **CIBA FOUNDATION STUDY GROUP NO. 8, PROBLEMS OF PULMONARY CIRCULATION**, Little, Brown and Co., Boston, 1961, pp. 96, \$2.50.

Ellis, Edward Robb and Allen, George N., **TRAITOR WITHIN, OUR SUICIDE PROBLEM**, Doubleday and Co., Garden City, New York, 1961, pp. 237, \$3.95.

Cherniack, R. M., M.D. and Cherniack, L., M.D., **RESPIRATION IN HEALTH AND DISEASE**, W. B. Saunders Co., Philadelphia, 1961, pp. 403.

Fluhmann, C. Frederic, M.D., **THE CERVIX UTERI AND ITS DISEASES**, W. B. Saunders Co., 1961, pp. 556.

Anderson, W. A. D., M.D., Ed., **FOURTH EDITION, PATHOLOGY**, The C. V. Mosby Co., St. Louis, 1961, pp. 1389.

REVIEWS

Toohey, M., M.D., **MEDICINE FOR NURSES**, Williams & Wilkins Co., Baltimore, Md., 1960, 667 pp., \$7.00.

THE BOOK COULD perhaps be improved through the collaboration of a nurse author but as an outline for quick reference it seems to have some value.

According to this reviewer, the physiological principles upon which good nursing care is based, do not seem adequately covered in this text. The book is profusely illustrated and contains many diagrams which may prove helpful to the young student nurse.

Sarah Helen Killgore

Acknowledgment of all books received will be made in this column and this will be deemed by the JOURNAL as full compensation for those sending them. Selection for reviews will be made at the discretion of the editor.

Sharman, Albert, M.D., **FROM GIRLHOOD TO WOMANHOOD**, Williams & Wilkins Co., Baltimore, Md., 1960, 72 pp., \$1.75.

THIS MONOGRAPH IS WELL WRITTEN. The medical terminology is transformed to lay terminology so that there should be no confusion because of language usage. The phases of development are well explained, but I believe that some of the fringe changes and reactions could be more completely explained and correlated. Chapter VI has a few too many statistics and chapters VII and VIII are a little advanced for girls to whom we would ordinarily recommend a book of this type. I heartily endorse the book for the older teen ager or young adult.

J. Harry Lange, M.D.

Foote, Rowden R., **VARICOSE VEINS**, Williams & Wilkins Co., Baltimore, Md., 1960, 356 pp., \$13.00.

THIS IS AN OUTSTANDING book dealing with the problem of varicose veins. Described as a manual; it is, rather, a most complete text on the subject. It is of value to all interested in the treatment of varicosities. Even the well-trained surgeon, experienced in the management of venous insufficiency, will benefit from its presentation.

Particularly impressive are the details of evaluation, operative technic, and positioning of the patient for surgery. The text, clearly written, is liberally illustrated with color and black and white photographs, in addition to drawings pertinent to the discussion of the various facets of information as they are presented.

An excellent bibliography and reference list is found at the end of each chapter. It is the most capable and complete source of information regarding the treatment of varicose veins that is available today.

P. C. Shea, Jr., M.D.

Francois, Jules, **HEREDITY IN OPHTHALMOLOGY**, The C. V. Mosby Company, St. Louis, 1961, 731 pp., \$23.00.

WITH THIS PRECISELY ORGANIZED and complete presentation of the science of genetics as related to ophthalmology, Jules Francois has contributed to a gap in our advanced ophthalmic literature references. New concepts of the gene, mutation, linkage, crossing-over and penetrance; along with the physiochemical and histochemical studies in the genetic constitution, and investigations of family trees are ably presented—invoking a deep concern for “the better selection of one’s parents and possibly grandparents.”

Genetics is shown not to be a barren science, and the need for research into its therapies is conclusive.

PHYSICIAN'S BOOKSHELF / continued

The fundamental laws as formulated by the Monk Johann Mendel in 1865 are brought to a wonderful exposition by Jules Francois in this volume, and it is well recommended for advanced interests in this area of medicine.

W. Granville Tabb, Jr.

Montgomery, Thaddeus L., M.D. and Greenblatt, Robert B., M.D., **CLINICAL OBSTETRICS AND GYNECOLOGY**, Vol. 3, No. 4, Paul B. Hoeber, Inc., New York City, 1961, pub. quarterly, \$19.00 per year.

THIS ISSUE OF THE QUARTERLY *Clinical Obstetrics and Gynecology* is divided between endocrinology and fetal physiology and distress. As editor of the latter section, Dr. Thaddeus L. Montgomery expresses the hope that the collected group of monographs will stimulate practicing obstetricians to set up hospital progress in clinical research which could add greatly to the present knowledge of fetal distress.

Dr. George W. Anderson reports the world-wide incidence of fetal distress to be 1.5 - 22.8 per cent, with an average of five - six per cent—thus showing the difficulty in establishing statistical controls on labor room observations, such as changes in fetal heart rate.

Dr. Edward H. Hon reports on his findings with continuous, fetal ECG in the labor room. He suggests that fetal brady cardia and the passage of meconium in vertex presentations may not necessarily be due to fetal hypoxia, but might be associated with increased vagal tone secondary to umbilical cord compression.

In another excellent chapter, Dr. Louis J. Hampton discusses resuscitation of the newborn and gives much deserved emphasis to the Apgar scoring system in establishing the degree of depression in the newborn. For the moderately to severely depressed infant, Dr. Hampton urges immediate endotracheal aspiration and artificial respiration.

Two other especially interesting articles concern maternal pre-diabetes, and the relation of fetal respiratory movements to hyaline membrane disease. The section of the relation of obstetrical analgesia and anesthesia to fetal distress deserves more detailed discussion. Another interesting addition would have been a discussion of the post-mature syndrome.

In the second half of the book, Dr. Greenblatt has organized an interesting symposium on endocrinology.

In separate chapters, the uses of estrogen, androgens, progestational agents, and cortisone in obstetrics and gynecology are outlined in a brief and understandable fashion. An adequate bibliography is available for the reader who desires more detailed information.

There is an excellent discussion on the thyroid gland in which the various tests of thyroid function are evaluated—emphasizing that more than one test is frequently needed for the diagnosis of impaired function.

In an excellent final chapter on hormones and cancer, Dr. Peter Bishop attempts to allay fear of inducing cancer through the administration of hormones.

This issue of *Clinical Obstetrics and Gynecology* continues to maintain the high standards set by the previous numbers.

Charles K. Wright, M.D.

DERMATOLOGY FOR STUDENTS. Edited by Ray O. Noojin, M.D., 301 pages. Chas. C. Thomas, 1961, Springfield, Ill. \$9.50.

ABOUT 90 PER CENT OF SKIN DISEASES in the clinics and private practice will be accounted for by some 25 dermatologic diagnoses. In our Medical Schools, the number of hours of teaching and clinics is limited. This is more often true in dermatology. It would seem logical to have the medical student master the diagnosis and treatment of the most common skin diseases, rather than face the frustration of trying to absorb too much in too short a time. Only confusion and uncertainty of diagnosis would result. The rare diseases and details should be left to the specialist. The "Dermatology for Students" is just what the title says. Twenty-seven common dermatoses are presented in an exceptionally brief and clear cut manner. Each contributor is a well known teacher of dermatology, professor or head of a dermatology department. This selection of talent from all parts of the nation makes the publication so much more intriguing.

Visual perception is most important in the comprehension and recognition of dermatological lesions. The 300 page volume has an excellent selection of clinical photographs and a 30 page color Atlas to fill in this need. The textbook should prove a classic for the medical student and general practitioner who diagnoses and treats most of his own skin problems.

William L. Dobes, M.D.

Stroke Clinic Gets Recognition

COVINGTON, GEORGIA, AND THE NEWTON COUNTY Stroke Rehabilitation Clinic there have gained wide recognition through a feature story in "The American Heart," a quarterly publication of the American Heart Association.

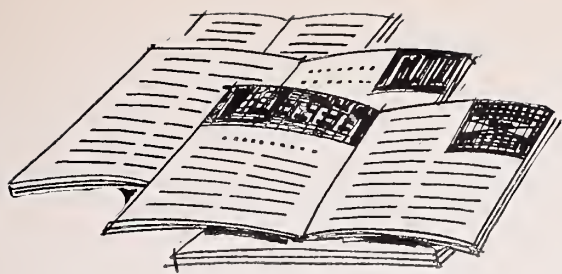
Three complete pages, including the front page, in the summer edition are devoted to a story and 11 pictures telling the background and progress of a unique educational project which has brought hope and renewed vitality to many stroke patients.

"The American Heart" is distributed to American Heart Association affiliates in all 50 states and

Puerto Rico and to physicians and medical groups throughout the world.

Its primary purpose is to report to the public the latest advances in research, education and community service in the field of cardiovascular disease.

The Covington clinic, sponsored by the Georgia Heart Association and the Newton County Heart Council, is conducted by volunteers and is designed primarily to restore the stroke victim's confidence and teach him how to rehabilitate himself by means of simple exercises which he can do in his own home.



current clinical concepts

Hypertension in Children

OWING TO THE RARITY of hypertension in childhood it is often overlooked. Measurement of blood pressure during routine physical examination of children is frequently omitted. Hypertension in childhood has a specific and detectable etiology usually attributable to acute and chronic glomerulonephritis, and less commonly to congenital pyelonephritis or disturbances of renal blood supply. Headache, mental changes, visual disturbances, nausea, vomiting and abdominal pain may all be presenting symptoms. This paper emphasizes the importance of detailed diagnosis and clinical follow-up in childhood hypertension.

Meilman, E., Kurtz, M. and Turner, L. B.: Hypertension In Childhood, *J. Mt. Sinai Hosp., N. Y.*, 28:196, March-April 1961.

The Hyperactive Child

THE HYPERACTIVE CHILD carries out his activities at a greater than average speed and intensity, is constantly in motion, or both.

Hyperactivity occurs with: 1) organic brain damage, 2) mental retardation without obvious brain damage, 3) reactive and neurotic behavior disorder, 4) childhood schizophrenia, and 5) without other pathology.

Treatment includes parental counseling, psychotherapy, sedative and tranquilizing medication and remedial education. Early diagnosis and suitable individualized therapy are stressed for insuring proper adjustment of the child to his environment.

Chess, S.: Diagnosis and Treatment of Hyperactive Child, *N. Y. State J. Med.* 60:2379, Aug. 1, 1960.

Early Diagnosis of Meconium Ileus

THIS RECENT REPORT INDICATES that it is possible to establish a preoperative diagnosis of meconium ileus with the aid of the pilocarpine iontophoresis sweat test with which sweat chlorides have been demonstrated to be abnormal as early as the first day of life.

Elian, E., Shwachman, H., and Hendren, W. H.: Intestinal Obstruction of the Newborn Infant: Usefulness of the Sweat Electrolyte Test in Differential Diagnosis, *New Eng. J. Med.* 264:13, 1961.

Diet and Undernutrition

COMPREHENSIVE 20-YEAR STUDY of more than 2000 children indicates that continuous undernutrition during infancy, childhood and adolescence affected the growth and maturation of the skeleton to a detectable degree although distortion of the whole bone was rare.

For successful treatment of nutritive and growth failure proper and persistent therapy must begin before damage becomes irremediable.

Dreizen, S., Stone, R. E. and Spies, T. D.: The Influence of Chronic Undernutrition of Bone Growth in Children, *Postgrad. Med.* 29:182, Feb. 1961.

Tubing Used in Exchange Transfusions

THE TUBING OF THE INTERNAL exchange transfusion apparatus connecting the tip of the syringe to the patient's circulation should be as short and narrow as possible to eliminate excess tube dead space.

An excess of "dead tube space," the volume in the tubing connecting the exchange transfusion syringe to the patient's circulation, materially reduces the efficiency of the process.

Trossman, C. M., Alzofon, F. E., and Malkin, H. M.: On Interval Exchange Transfusions, *A.M.A. Jour. Dis. Child.* 102:194, 1961.

Significance of an Absent Umbilical Artery

IN STUDYING 1,500 CONSECUTIVE deliveries the authors found that only one, instead of the customary two, umbilical artery occurred in 1 per cent of the deliveries. In a study of 113 cases in which only one umbilical artery was present, there was an associated mortality involving 58 per cent of affected infants plus a further 12 per cent alive but abnormal infants. Aplastic lesions of the gut and urinary tract were the most frequently occurring major anomalies. Quick warning to the pediatrician that only one umbilical artery exists correcting it before the infant's life is lost.

Bourne, G. L., and Benirschke, K.: Absent Umbilical Artery: A Review of 113 Cases, *Arch. Dis. Child.* 35:534, 1960.

MAG KING BILL TESTIMONY

On August 1, 1961, Association Secretary John T. Mauldin presented MAG testimony in opposition to the King Bill (H.R. 4222) to the House Ways and Means Committee, Washington, D. C., at the direction of MAG Council. A 14 page document of MAG testimony was filed with clerk of the Ways and Means Committee and the following summary was presented orally by Dr. Mauldin—in that time would not permit the reading of the full testimony to the Committee. For your information and record, the oral statement submitted by MAG witness Mauldin is printed herein:

I wish to thank you for the opportunity of presenting a statement in behalf of the Medical Association of Georgia.

I am John T. Mauldin, M.D., Secretary of the Medical Association of Georgia, and Chairman of the Governor's Commission on Aging.

My statement has been presented in writing to the Clerk and I wish to present to you at this time a short summary and explanation. It is requested that the full statement be included on the records of this hearing.

The doctors of Georgia have been cognizant of the problems of medical care for the aged for a number of years and have been working toward a solution.

Working jointly with the Georgia Hospital Association, Georgia Association of Hospital Governing Boards and the State Health Department, we drafted the Health Indigent Care Program. This program, designed for all ages, financed by joint state and county funds, is under consideration by state fiscal agents and will be probably activated within the very near future.

Georgia doctors are on public record that physician care will be rendered at no cost under this program.

The Medical Association of Georgia, appointed at the request of the Governor, a committee that studied the mental health facilities in Georgia. The report resulted in the expenditure of approximately 12 million dollars for facilities and program changes that have produced tremendous improvement. There are 12,000 mental patients of which 3,000 are over 65.

The State Aid Cancer Program for indigent cancer patients of all ages is financed by state and federal funds. About \$400,000 was spent last year; \$15,000 of which was federal and the rest state. Some 4,000 patients were treated, of which 45 per cent were over 65. The doctors of Georgia donate their services without charge, doing the examinations, diagnosis and performing the necessary surgery.

The implementing legislation for the Kerr-Mills bill has been passed. The doctors of Georgia took an active part in drafting the bill and its passage through the state legislature. It is expected that the Governor will make an announcement within a week as to the extent of its *implementation. The doctors of Georgia have felt that doctors' fees should not be included in the estimated cost of implementation.

There are other factors that should be taken into consideration in estimating the situation in Georgia. Approximately 60 per cent of the people in Georgia have voluntary prepaid health insurance. The number

of those over 65 was not available, but 40 companies licensed in Georgia write a guaranteed renewable life-time policy for those over 65.

Veterans over 65 are in many instances eligible for hospital, domiciliary and some out-patient care. There are at present in Georgia some 3,700 hospitalized and domiciled veterans, with an additional 40,109 receiving out-patient care.

Civil service employees are eligible for hospital and medical insurance under P. L. 86-382 after retirement.

Also, the State of Georgia is working out a program of hospital and medical insurance for its employees. Retired employees will presumably be able to continue this insurance.

Armed forces retired personnel and their spouses may receive treatment at armed forces' hospitals.

Statistically, Mr. Chairman, there is no need in Georgia for the enactment of H. R. 4222. In fact, just the opposite is true. For this reason I appear here today as spokesman for the Medical Association of Georgia to urge that you reject this bill. I want to place the doctors of Georgia squarely on record as thoroughly opposed to the enactment of this bill.

As free citizens, dedicated to the continuance of free institutions, we soundly reject any legislative proposals based on compulsion.

Mr. Chairman, in Georgia we believe that as a matter of principle that the closer to home a government is, the more responsive it is to the needs and wishes of the people. A program as vast as H. R. 4222 envisions, would require regulations so detailed and so exacting as to seriously jeopardize the quality of medical care in this country.

Mr. Chairman, may I point out that the doctors are not the only Georgians that feel this way, but that the state legislature, composed of duly elected representatives of the people, passed a resolution; H. R. 538, in which it stated that:

"... this House hereby expresses its opposition to federal legislation designed to increase social security taxes by encroaching on the legitimate and most effective function of the community in caring for its own problems of the health care of the aged."

We recognize, Mr. Chairman, that there are certain needy people and others whose marginal income would classify them as near needy. H. R. 4222 goes far beyond this. It may be possible that in the name of humanity, *need* can justify many things. But, in the name of fiscal responsibility and maintenance of free institutions, *need* must exist to justify the expenditure of public moneys.

In conclusion I urge you to reject H. R. 4222 as an invalid instrument, inconsistent with the American tradition of self-reliance and individual responsibility.

Again may I thank you for the privilege and opportunity of appearing here today.

* On August 8, 1961, Governor S. Ernest Vandiver publically announced that the Georgia Medical Assistance to the Aged Act as passed by the Georgia General Assembly in 1961 would be implemented in the amount of some seven million dollars to become effective January 1, 1962.



abstracts by georgia authors

Haltiwanger, Earl, V.A. Hosp., Atlanta 19, Georgia, "Effect of Furacin on Testicular Tumor," J. Urol. 86:125-126 (July) 61.

As early as 1950 the nitrofurans were noted to cause suppression of the germinal elements of the testes. Since that time they have been found to cause a decrease in cellularity and an increase in fibrosis in some human testicular tumors. However, their use is somewhat limited by the unpredictable complications of nausea and disabling peripheral neuritis.

A case is presented of a 35-year old patient with embryonal carcinoma and metastatic lung lesions. A daily dose of 1.5 Grams of oral Furacin was given for two months. At the completion of treatment all lung lesions had disappeared and urinary gonadotropins had returned to normal. No complications of therapy occurred. One year later the patient is living and well and without evidence of disease.

Vaughan, Victor C., III, M.D., Medical College of Georgia, Augusta, Georgia, "The Problem of Hyperbilirubinemia," South. M. J. 54:725-731 (July) 61.

The problem of hyperbilirubinemia in the newborn infant is reviewed, with attention given to those physiologic handicaps of the newborn infant which normally dispose to an elevation of serum bilirubin in the first few days of life, to factors which intensify this tendency to hyperbilirubinemia, and to factors which, in the presence of established hyperbilirubinemia, tend to make the occurrence of kernicterus more likely.

Icterus neonatorum is seen to be principally the result of temporary non-function of the hepatic enzymatic process for conjugation of indirect bilirubin with glucuronic acid to form the direct reacting pigment. Icterus neonatorum is reported to be clinically evident in about 35 per cent of white infants and 15 per cent of Negro infants. More white boys are affected than white girls; there is no apparent sex difference in the Negro. Other factors modifying or intensifying icterus neonatorum are premature birth and major blood group incompatibility, the latter making only a small contribution. Anoxia, infection, and administration of drugs (including water-soluble vitamin K) may further aggravate icterus neon-

atorum, possibly through promotion of hemolytic activity dependent upon glutathione instability.

The susceptibility of the icteric newborn infant to kernicterus may be greatly enhanced by administration of substances which compete with bilirubin for binding sites on albumin, which normally serves as the medium of transport for bilirubin in serum. Administration of sulfonamide drugs, in particular, is hazardous to the icteric newborn infant.

Kernicterus is nearly always preventable if the level of serum bilirubin can be kept below 20 mg. per 100 ml. The way in which exchange transfusion is used to achieve this goal is discussed, with emphasis upon the necessity for accurate determination of levels of serum bilirubin.

Bottomy, John R., M.D., and Boyd, Richard A., M.D., Emory University, Georgia, "The Clinicians Dilemma: Conization for Evaluation of Carcinoma in Situ of the Cervix in Pregnancy," South. M. J. 54:584-593 (June) 61.

Fifteen cases biopsied during pregnancy on the basis of clinical suspicion alone were coned because of pathological findings histologically meeting all criteria for carcinoma in situ.

Four specimens were found to be early invasive carcinomas and managed as such. Six were diagnosed as carcinoma in situ, three suspicious of carcinoma in situ, and in two the biopsy diagnosis was not confirmed by cone.

Merrill, Arthur J., M.D., 35 Fourth Street, N.E., Atlanta 8, Georgia, "Management of the Nephrotic Syndrome," Am. Heart J. 61:719-722 (June) 61.

Corticosteroids used aggressively in nephrotic subjects produces diuresis in 90 per cent and reduces albuminuria in the majority. While the underlying disease may not be altered, investigators agree that death is at least deferred in many patients. Bilateral cataracts, symmetrical bilateral aseptic necrosis of the femoral heads and mandibular condyles and collapse of the vertebral bodies are some of the more serious complications of prolonged high dosage therapy. There seems to be no choice of type of preparation, but triamcinolone has produced a marked muscular weakness in two subjects

which necessitated withdrawal. Prophylactic antibodies achieve no advantage and may possibly promote invasiveness of unusual organisms, especially gram negative bacilli. The complicated case requires ingenuity, but efforts may be rewarded with at least partial success. Chlorothiazide is very helpful in the control of edema, but does not affect proteinuria. Spirolactone alone has no beneficial effect on edema or proteinuria. The advantage of having the family test the urine daily for protein is pointed out.

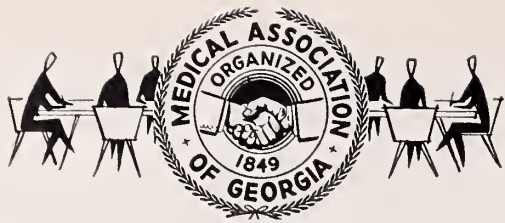
Engler, Harold, M.D.; Headley, William, M.D.; Clough, L. R., M.D.; and Moretz, William H., M.D., Medical College of Georgia, Augusta, Georgia, "The Effect of Fibrinolysin on the Incidence of Thrombosis in Small-Artery Suturing," Angiology 12:152-154 (May) 61.

This study illustrates the high incidence of thrombotic occlusion of anastomoses in small arteries.

The incidence of thrombosis occurring at end-to-end anastomoses in small transected arteries in a group of dogs receiving fibrinolysin intravenously is compared with that of a group of similar dogs not receiving fibrinolysin. The effect of fibrinolysin on thrombosis in longitudinal arteriotomies was studied similarly. Under the conditions of these experiments no benefit from the fibrinolysin could be demonstrated in the prevention of thrombosis in the transected group. It may be that the factors favoring the formation of a thrombus at the circumferential suture line of these vessels are so strong that thrombosis cannot be prevented by the action of fibrinolysin alone.

In longitudinal incisions the incidence of thrombosis was lower than in transections whether fibrinolysin was administered or not. With the use of fibrinolysin this incidence of thrombosis was only 11 per cent as compared with 25 per cent when no fibrinolysin was used. This suggests that, under the conditions of this experiment, fibrinolysin was used. This suggested that, under the condition of this experiment, fibrinolysin may have offered some degree of protection against thrombosis at longitudinal suture lines.

* The fibrinolysin used in this study was supplied as Actase Fibrinolysin (Human) by the Ortho Pharmaceutical Corporation, Raritan, New Jersey.



the association

DEATHS

EVERETT A. BARGERON, 55, of Waynesboro died August 27, 1961, at his home. Dr. Bargeron attended the Waynesboro High School and was a graduate of the Georgia Military Academy. He attended Mercer University and was graduated from the Medical College of Georgia in 1931. He was a practicing physician in Waynesboro for 25 years.

He was a member of Burke County Medical Society, the Medical Association of Georgia, the American Medical Association, and the First Methodist Church of Waynesboro.

He is survived by his wife, Virginia Phelps Barger on of Waynesboro; three daughters, Mrs. Clyde E. Lastinger, Daytona Beach, Fla., Miss Peggy Barger on, Decatur, and Miss Ginny Barger on, Waynesboro; his mother, Mrs. Ada Barger on, Waynesboro; and two grandchildren.

FORREST L. COSBY, 64, Muscogee County Physician for the past 20 years, died August 26, 1961 at his residence in Columbus. Dr. Crosby was a graduate of Emory University and attended the University of North Carolina Public Health School. He was a veteran of World War I, a member of the American Legion, Shrine Club and a Mason. He was a member of the Muscogee County Medical Society, the Medical Association of Georgia and the American Medical Association.

He is survived by his wife, Ellen Mitchell Cosby, Columbus; three daughters, Mrs. Jeff Kelly, Jr., and Mrs. Robert L. Hayes, both of Columbus and Mrs. Joe B. Ellis of Atlanta; two sisters, Mrs. Nina C. Bryant and Mrs. Myrtle C. Hood, both of Columbus; and seven grandchildren.

CLIFFORD CLAYTON ELLIOTT, Sargent, died July 18, 1961 at the age of 73. Dr. Elliott graduated from the Chattanooga School of Medicine in 1910. He did his residency at Bellevue Hospital and Lying-In Hospital in New York City as well as house-to-house internship in New York's Chinatown. After practicing medicine in Alabama for a year he moved to Sargent where he practiced until his death.

Dr. Elliott was a member of the Coweta County Medical Society, the Medical Association of Georgia, the American Medical Association, the Masons, and the First Methodist Church of Newnan.

He is survived by his wife Celestia Sewell Elliott, two sons and a daughter.

EUSTACE H. PRESCOTT, 66, director of the Troup County Health Department, died September 8, 1961 at

his home in LaGrange. Dr. Prescott received his BS degree at South Carolina Coeducational Institute in 1912 and his M.D. from the Medical College of South Carolina in 1918, and interned at St. Francis Infirmary, Charleston, S. C. He retired from the Navy in 1946 with the rank of commander.

He was a member of the First Baptist Church in LaGrange, LaGrange Elks Lodge, LaGrange Moose Lodge, Troup County Medical Society, LaGrange Kiwanis Club, American Medical Association, American Public Health Association, Medical Association of Georgia, Georgia Public Health Association, and the American Legion.

Survivors include his wife, Alpha H. Prescott of LaGrange; three sons, Cmdr. E. H. Prescott Jr., U. S. Navy Medical Corps, Naval Hospital, Pensacola, Fla., William Lewis Prescott, Columbia, S. C., and Edward C. Prescott, Augusta; and seven grandchildren.

LOUIS C. ROUGLIN, 82, died September 9, 1961 in a private hospital in Atlanta after an extended illness. He graduated from Atlanta College of Physicians and Surgeons, New York University, Bellvue Medical College, and Manhattan Eye, Ear, Nose and Throat College.

Dr. Roughlin received a certificate of distinction from the Fulton County Medical Society in 1951 for 50 years of service. He was a member of the Society for 60 years, and remained in active practice until he was past 80. He was a member of the Temple, the Masons and Shriners, the Fulton County Medical Society, The Medical Association of Georgia, and the American Medical Association.

He is survived by his wife Lena Roughlin of Atlanta and a sister, Mrs. Anne Chertok of Los Angeles.

SOCIETIES

Members of the HALL COUNTY MEDICAL SOCIETY are cooperating with the two local school systems in a new program aimed at protecting high school football players this year. They will provide check-ups and a doctor at each game.

The THOMAS COUNTY MEDICAL SOCIETY held its quarterly meeting September 21. The guest speaker, Dr. Robert B. McIver, Jacksonville, Fla., spoke on "Correction of Upper Urinary Tract Obstruction."

Members of the STEPHENS COUNTY MEDICAL SOCIETY are giving their services to the Stephens County and Toccoa High Schools during football season.

The OCMULGEE MEDICAL SOCIETY met in Hawkinsville during the middle of September. Braswell Collins of Macon spoke on "Current Medical Legislation."

PERSONALS

First District

Dr. J. Lane Reeves recently joined J. HARRY DUNCAN and FRANKLYN P. BOUSQUET in the practice of ophthalmology in Savannah.

JAMES L. ALEXANDER of Savannah recently spoke to the Savannah Exchange Club on tuberculosis.

Second District

The SECOND DISTRICT MEDICAL SOCIETY held their semi-annual meeting the first of this month in Bainbridge. The scientific program included talks on obesity, medical education, urology, and heart sounds.

Third District

CLARENCE C. BUTLER of Columbus was elected president of the Georgia Heart Association at their recent meeting at Jekyll Island. Other officers include: WILLIAM B. FACKLER JR., of LaGrange, president-elect, HARRY H. BRILL of Columbus a director, and SIMONE BROCATO also of Columbus a delegate to the assembly of the American Heart Association.

HENRIETTA JERECH spoke in September to the Columbus Business and Professional Club on "Menopause, Its Physiological, Psychological and Social Aspects."

Fourth District

THOMAS N. FREEMAN of LaGrange was a candidate in the local mayoralty race which ended the first of the month.

Fifth District

THOMAS C. McPHERSON, of Atlanta, was named in September as an Associate Medical Director of Mead Johnson Laboratories.

BRUCE LOGUE was recently guest lecturer at the Mayo Clinic. The title of his talk was "Clues on Inspection of the Patient with Cardiovascular Disease."

CARL A. WHITAKER, member of the Atlanta Psychiatric Clinic addressed the Stephens County Mental Health Association in September. The topic was "Out-patient Counseling of the Alcoholic."

Sixth District

C. S. JERNIGAN recently celebrated the 64th anniversary of his arrival in Sparta to practice medicine.

Seventh District

ROBERT L. RAITZ is now associated with EARL T. McGHEE in the practice of general medicine in Dalton.

DON SCHMIDT of Cedartown addressed the Canton Lions Club in September. He is the district governor 18-A.

Eighth District

VILDA SHUMAN of Waycross has been re-appointed State Advisor on Womens Activities of the National Foundation in the Eastern Georgia Area for the March of Dimes.

Ninth District

No news submitted.

Tenth District

"An American Surgeon's View of Thailand" was given recently by GEORGE F. McINNES in a talk to the Augusta Junior Chamber of Commerce.

THOMAS W. GOODWIN, of Augusta, spoke in September to the local Lions Club on "Problems Involved in Socialization of Medicine."

JOHN N. SHEAROUSE, of Lavonia, recently was appointed to the State Medical Education Board by Gov. Ernest Vandiver.

VICTOR C. VAUGHN III, of Augusta, spoke on "Observations on the Limbal Form of Vernal Catarrh" at the American Academy of Pediatrics in Chicago the first of the month.

EXECUTIVE COMMITTEE OF COUNCIL MEETING, AUGUST 27, 1961

THE AUGUST MEETING of the Medical Association of Georgia Executive Committee of Council was called to order by President and Chairman Fred H. Simonton at 10:10 A.M. at MAG Headquarters Building, August 27, 1961.

The members of the Committee present were: Fred H. Simonton, Chickamauga; President and Chairman; Thomas W. Goodwin, Augusta, President-Elect; George H. Alexander, Forsyth, Chairman of Council; Milford B. Hatcher, Macon, Immediate Past President; John T. Mauldin, Atlanta, Secretary; J. G. McDaniel, Atlanta, Chairman of Finance; and Linton H. Bishop, Jr., Atlanta, First Vice President. Also present were Edgar Woody, Jr., Atlanta, Editor, JMAG; J. Frank Walker, Atlanta, Chairman, Board of Session; R. C. Pendergrass, Americus, Chairman, Cancer Sub-Committee; Mr. James Baker, Acting Medicare Administrator; Mr. M. D. Krueger, Executive Secretary; Mr. James M. Moffett, Assistant Executive Secretary; and Mrs. Catherine Wooten, Executive Assistant.

The minutes of the July 22-23 Executive Committee meeting were read by Mr. Krueger. On motion duly made and seconded the minutes were approved as read.

MAG Medicare Policy on Publication of Fees

Mr. Baker discussed the modified contract from Washington regarding non-publication of fees. On motion (McDaniel-Alexander) it was voted to send all of the County Medical Society Presidents and Secretaries a copy of the manual and a letter of explanation that after October 1st, a manual with the fees listed could not be published.

President Simonton asked for a decision regarding the signing of the contract modification. After discussion, on motion (Mauldin-McDaniel) it was voted to accept this modification and sign the contract.

Legislation Board Report

Dr. Walker stated that all actions of the MAG House of Delegates have been completed. He then read the names of the suggested members of two proposed sub-committees of his board, the National Legislative Sub-Committee and the State Legislative Sub-Committee. On motion duly made and seconded the following members were approved:

National Legislative Sub-Committee
J. Frank Walker, Atlanta, *Chairman*
1st. District—T. A. Peterson, Savannah
2nd. District—Frank McKemie, Albany
3rd. District—Robert Pendergrass, Americus

- 4th. District—J. W. Chambers, LaGrange
- 5th. District—Thomas Florence, Atlanta
- 6th. District—John Bell, Dublin
- 7th. District—Howard Derrick, LaFayette
- 8th. District—Horace Joiner, Douglas
- 9th. District—C. J. Roper, Jasper
- 10th. District—R. H. Randolph, Athens

State Legislative Sub-Committee

John Bell, Dublin, *Chairman*
 Thomas Florence, Atlanta
 Frank P. Holder, Eastman
 Albert Deal, Statesboro
 Robert Quattlebaum, Valdosta
 Braswell Collins, Macon
 P. K. Dixon, Gainesville
 A. W. Simpson, Jr., Washington
 Jack Austin, Griffin

Dr. Walker also requested approval of appointment of Maurice F. Arnold, Hawkinsville, to the Board of Legislation. It was recommended that Dr. Walker contact Dr. Arnold regarding acceptance of this appointment. The District meetings were discussed, particularly the one scheduled by Dr. Deal of Statesboro. On motion (Mauldin-Alexander) it was voted to take \$200.00 from Legislative Board fund for Dr. Deal's meeting and it was recommended that the Chairman of the Executive Committee write Dr. Deal to this effect. It was also recommended that a portion of the Legislative Board report be referred to Council. On motion duly made and seconded the Legislation Board report was approved as presented.

MAG Journal Report

Dr. Edgar Woody discussed the decrease in advertising in the Journal and the expenditures from the budget. He was commended by the Executive Committee for his work on the Journal.

1962 MAG Annual Session Report

Annual Session Board Chairman Peter Hydrick first discussed the floor plan for the 1962 Annual Session in Savannah and explained the hospital size commercial exhibit plan for consideration. On motion (McDaniel-Alexander) it was voted to accept Dr. Hydrick's recommendation for the new type of exhibit. The proposed scientific program as follows was discussed:

1962 Savannah MAG Annual Session Scientific Program

Sunday Afternoon, May 6 at 2:30 P.M. to 5:00 P.M.

- (1) PEDIATRICS and SURGERY—JOINT SECTION
- (2) DERMATOLOGY and E.E.N.T.—JOINT SECTION
- (3) ANESTHESIOLOGY SECTION
- (4) ORTHOPEDICS SECTION
- (5) RADIOLOGY SECTION

Monday Morning, May 7 at 9:00 A.M. to 12:00 NOON

- (1) CHEST, DIABETES, MEDICINE and PSYCHIATRY JOINT SECTION
- (2) OBSTETRICS, UROLOGY, PEDIATRICS and SURGERY JOINT SECTION
- (3) RADIOLOGY, ORTHOPEDICS and PATHOLOGY JOINT SECTION

Tuesday Morning, May 8, at 9:00 A.M. to 12:00 NOON

- (1) GENERAL SESSION—GP DAY MEETING

Tuesday Afternoon, May 8, at 2:30 P.M. to 5:00 P.M.s

- (1) GENERAL PRACTICE and PSYCHIATRY JOINT SECTION MEETING
- (2) MEDICINE, CHEST and DIABETES JOINT SECTION MEETING
- (3) OBSTETRIC SECTION MEETING

On motion (Alexander-McDaniel) it was voted to approve this program. It was suggested that an interesting panel be scheduled for Monday, May 7, 1962, DeSoto Ballroom, Chest, Diabetes, Medicine and Psychiatry Joint Section, before the Business Meeting. Dr. Hydrick asked Executive Committee's opinion on holding a Medical-Legal Workshop for the Annual Session with Dr. Herman Jones as Chairman. On motion (Hatcher-McDaniel) it was voted to approve this Workshop. Dr. Hydrick also requested the designation of an Annual Ses-

sion Speaker. On motion duly made and seconded it was voted to ask an AMA speaker, and the Chairman of the Executive Committee, Chairman of Council and the President-Elect were designated to make the selection.

Cancer Sub-Committee Report

Dr. Robert Pendergrass discussed the non-appropriation of state funds and the non-acceptance of new patients after January 1, 1962. After general discussion, and on motion (Hatcher-McDaniel) it was voted to instruct the Secretary to compose a letter to Dr. Simonton to be presented at the next State Board of Health meeting. This letter should quote the law, if helpful, and should request that the Board of Health contact the Governor for more funds. Dr. Pendergrass asked for approval of appointment of additional members to his sub-committee as follows: Enoch Callaway, LaGrange; Everett L. Bishop, Atlanta; Thomas Harrold, Macon; Robert L. Brown, Atlanta; and John T. Godwin, Atlanta. On motion duly made and seconded these additional members were approved.

Relative Value Study Committee Report

Mr. Krueger gave a report on the August 20th meeting of the Relative Value Study Committee. Dr. McDaniel gave additional information regarding the State Employees Health Insurance Plan. At the request of the Chairman of this Committee, Dr. Harry Pinson, Mr. Krueger read a list of additional members to the committee, for which approval was requested. They are as follows: Robert A. Matthews, Albany; Walter G. Thwaite, Columbus; H. Walker Jerigan, Atlanta; H. Lee Howard, Jr., Savannah; Robert J. Black, Rome. On motion duly made and seconded it was voted to approve the appointment of the above additional members to the Relative Value Study Committee, and to approve the action of the committee regarding the MAG Relative Value Study that MAG accept the California Plan with a coefficient derived additional study. It was suggested that the Relative Value Study Committee recommendations be made to Council at the September meeting.

Board and Sub-Committee Functions and Appointments

(1) Interprofessional Relations Board Function: At Dr. McDaniel's request it was explained that the Chairman of this Board should recommend members to the Executive which he wishes appointed to other groups not already covered.

(2) Paramedical Education Clarification: A letter from Dr. Dillenger was read stating that according to his interpretation of the MAG Constitution and Bylaws, Paramedical Education should be under the Board of Medical Education and not under the Board of Hospital Activities, as previously designated by the Executive Committee. On motion duly made and seconded it was voted to change the Paramedical Education (Sub-Committee on Clarksville Laboratory) to the Board of Medical Education, to correct the previous action of the Executive Committee.

(3) School Child Health: Mr. Krueger read a letter from the previously appointed Chairman of this sub-committee regarding his inability to accept the chairmanship. On motion duly made and seconded John Bowen, Sandy Springs, was appointed chairman.

(4) Disaster Medical Care Sub-Committee: On the recommendation of Dr. Wolff, Chairman of the Board on Governmental Medical Services, and the Chairman of the above sub-committee, the following members of this committee were approved: Edgar M. Dunstan, Atlanta, Chairman; W. Harrison Reeves, Atlanta; Charles E. Dowman, Atlanta; Lee H. Battle, Jr., Rome; P. Volpito, Augusta; W. D. Hazlehurst, Macon; T. J. Ferrell, Waycross; George M. Hutto, Columbus; J. L. Elliott, Savannah; Virgil Williams, Griffin; Lester Petrie, Atlanta, Ex-officio; and Mrs. Kells Boland, Atlanta, Ex-officio.

It was recommended that the Secretary write the Chairman of the Disaster Medical Care Sub-Committee that Council would like to hold a meeting to alert the public on Disaster Medical Care and would like the Chairman to look into the possibility of such a meeting and report to Council. On motion (Mauldin-McDaniel) this recommendation was so approved.

(5) Maternal and Infant Welfare Sub-Committee: On the recommendation of Dr. Wolff, Chairman of the Board on Governmental Medical Services, and the Chairman of the above sub-committee, the following members of this committee were approved: *Maternal Mortality Group*: Eugene L. Griffin, Atlanta, Chairman; H. J. Bickerstaff, Columbus; Peter Hydrick, College Park; Helen W. Bellhouse, Atlanta; J. W. Smith, Man-

chester; A. G. LeRoy, Thomson; C. I. Bryans, Augusta; Luella M. Klein, Atlanta; and H. A. Wasden, Jr., Pavo; *Perinatal Mortality Group*: W. E. Laupus, Augusta, Chairman; Eugene L. Griffin, Atlanta; James W. Bennett, Augusta; Helen W. Bellhouse, Atlanta; John P. Jones, Macon; J. H. Patterson, Atlanta; John D. Thompson, Atlanta; and Lillian Warnick, Atlanta.

(6) Rehabilitation Sub-Committee: On the recommendation of Dr. Wolff, Chairman of the Board on Governmental Medical Services, the following members of this committee were approved: Robert L. Bennett, Warm Springs, Chairman; F. James Funk, Jr., Atlanta; Jack Mohny, Augusta; Vernon E. Powell, Atlanta; W. Upton Clary, Savannah; Mercer Blanchard, Columbus; and Thomas P. Goodwyn, Atlanta.

(7) Crippled Children Sub-Committee: On the recommendation of Dr. Wolff, the following members of this committee were approved: Ernest B. Dunlap, Jr., Atlanta, Chairman; J. C. Hughston, Columbus; F. James Funk, Jr., Atlanta; John L. Chandler, Jr., Augusta; H. M. Coe, Brunswick; Robert Mabon, Atlanta; James W. Bennett, Augusta; W. G. Elliott, Cphthbert; Ruth M. Warning, Savannah; Atwood M. Freeman, Jr., Albany; and Walter P. Barnes, Jr., Macon.

These appointments rescind the action of the Executive Committee at a previous meeting, at which time the Crippled Children and Rehabilitation groups had been combined into one committee. After subsequent consideration it was decided to make separate sub-committees of these two groups.

MAG HR 4222 Testimony Report

Secretary Mauldin reported on his appearance before the House Ways and Means Committee in Washington to testify in opposition to the King-Anderson Bill (HR 4222). The Executive Committee commended Dr. Mauldin and Mr. Krueger for their efforts.

Board of Health Data Report

President Simonton discussed paramedical personnel project in a letter from Dr. John T. Godwin, Georgia Association of Pathologists President. It was recommended that the Secretary write Dr. Godwin for more details about the project, with a copy of the letter to the Chairman of the State Board of Health.

Dr. Simonton also reported on Kerr-Mills implementation proposals at the recent State Board of Health meeting.

U.S. Chamber of Commerce Presidents' Conference

President Simonton also asked Executive Committee consideration of sending a representative to the U. S. Chamber of Commerce "Presidents Conference on Public Affairs" meeting, October 10, 1961, St. Louis, Missouri. It was recommended that President-Elect Goodwin attend the meeting. Mr. Krueger was asked to write the organization that Dr. Goodwin would represent MAG. On motion duly made and seconded it was voted to pay Dr. Goodwin's expenses from Officers Travel.

MAG Treasurer's Report

Mr. Krueger gave the Treasurer's report in Dr. Arp's absence. On motion duly made and seconded the report was approved as read.

Venable Letter

Dr. Mauldin read a letter from John H. Venable, Director, State of Georgia, Department of Public Health, regarding a pilot program on home care service and all inclusive out-patient service for older people in Georgia. There was general discussion about this and further information was desired. Therefore, it was recommended that the Secretary write Dr. Venable for more detail.

MAG Staff Retirement Plan

Dr. Mauldin requested deferrment until the next meeting.

Previous Business Items

(1) Medic Alert Foundation: Dr. Bishop asked for deferrment until he has discussed this with the Board of Public Service, after which he will report to the Executive Committee.

(2) Vocational Education Liaison: Dr. Hatcher reported he has not heard from Miss Fannie Mae Walker and requested that Mr. Krueger write her and send a copy of this letter to Dr. Pope Jarrell. After consultation with Miss Walker Dr. Hatcher will make a report to the Executive Committee.

(3) Allied Medical Careers Clubs, Inc., Sponsorship: The Executive Committee voted to approve this sponsorship after the

Secretary makes a further investigation.

(4) MAG Scientific Awards: Dr. Bishop asked for a deferrment of this item or further investigation and stated he would make a report at a later date.

(5) Nursing Home Accreditation Liaison Appointment: On motion duly made and seconded it was voted to appoint Dr. Hatcher and Dr. Mauldin as liaison members.

General Correspondence

For Action:

(1) American Academy of Allergy Request: It was suggested that this request for data pertaining to insect bites be placed in the Journal as either a notice or an editorial, mentioning that W. G. Tyson, Savannah, or Carl C. Jones, Jr., M.D., Atlanta, could be contacted for the forms.

(2) AMA Biographical Data Request for Committee Appointments: Drs. Wolff and Hatcher were recommended for appointment to AMA Committees.

(3) Georgia PTA Cooperation Request: J. L. Hawk, Atlanta, appointed as liaison to Georgia P.T.A. and approval given for listing MAG as cooperating agency.

For Information:

(1) Workman's Compensation Coverage: It was announced that the MAG Attorney had rendered an opinion that this coverage was not necessary for MAG employees.

(2) AMPAC Criticism Letter: Received for information.

(3) Hospital Association Data: It was suggested that the Secretary ask the Georgia Hospital Association to poll their members on their stand regarding the Kerr-Mills Bill.

(4) Arkansas Letter: Received for information.

Headquarters Office Report

Mr. Krueger informed the Executive Committee of the employment of one general secretary, Miss Brenda Wallis, on August 24, 1961. He also stated the other general secretary, Miss Jane Cotter, is resigning on August 31, 1961, and he is seeking a replacement for her.

Unfinished Business

(1) Gulf Life Letter: It had been Dr. Hatcher's suggestion that the Gulf Life Insurance Company should write MAG that the mortgage is not in default so that the Association would have this in writing.

(2) Civil Defense Meeting: Notice of a Civil Defense meeting in Los Angeles, October 16-20, was read. On motion duly made and seconded it was voted not to send a representative.

(3) Date and Site and next Executive Committee meeting: To be decided later.

New Business

(1) Professional Conduct: There was general discussion regarding certain professional conduct problems.

There being no further business the meeting was adjourned at 5:20 P.M.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING, SEPTEMBER 16, 1961

THE MEETING OF THE Council of the Medical Association of Georgia was called to order by Chairman George H. Alexander at 2:05 P.M., September 16, 1961, at the King and Prince Hotel, St. Simons Island, Georgia.

The invocation was given by Dr. Goodwin.

Council members present were: George H. Alexander, Forsyth, Chairman of Council; Fred H. Simonton, Chickamaugua, President; Thomas W. Goodwin, Augusta, President-Elect; Lee H. Battle, Rome, Second Vice President; C. Raymond Arp, Atlanta, Treasurer; J. Frank Walker, Atlanta, Speaker of the House; Joseph B. Mercer, Brunswick, Vice Speaker of the House; Charles E. Bohler, Brooklet, First District; George Dillinger, Thomasville, Second District; W. Frank McKemie, Albany, Second District Vice Councilor; Frank Wilson, Leslie, Third District; Virgil Williams, Griffin, Fourth District; Floyd Sanders, Decatur, Fifth District; William Rawlings, Sandersville, Sixth District; Ralph W. Fowler, Marietta, Seventh District; C. R. Andrews, Canton, Ninth District; Addison Simpson, Jr., Washington, Tenth District; F. G. Eldridge, Valdosta, Eighth District; James M. Hicks, Brunswick, Eighth District Vice Councilor; Walter Brown, and T. A. Peterson, Savannah, Georgia Medical Society; J. G. McDaniel, Atlanta, Fulton County Medical Society; Luther Wolff, Columbus, Muscogee County Medical So-

ciety. Guests present were: H. E. Weems, Perry; W. A. Spears, Warner Robins; David R. Thomas, Augusta; Mr. John Moore, MAG Attorney and Mr. Richard Nelson, AMA Field Representative. Staff members present were Mr. Milton D. Krueger, Executive Secretary; Mr. James M. Moffett, Assistant Executive Secretary and Mrs. Catherine Wooten, Executive Assistant.

The minutes of the Council meeting of June 10-11, Executive Committee meetings June 9-10, July 22-23 and August 27, 1961 were read by Mr. Krueger. On motion duly made and seconded these minutes were approved as read, with a change in the August 27th minutes to read as follows: "BOARD OF HEALTH DATA REPORT—President Simonton discussed paramedical personnel project in a letter from Dr. John T. Goodwin, Georgia Association of Pathologists President. It was agreed by the Executive Committee that there is a need for more technicians, and it was recommended that the Secretary write Dr. Godwin for more details about the project, with a copy of the letter to be sent to the Chairman of the State Board of Health." After this change was made the minutes were approved as read.

Podiatry Liaison Clarification

Mr. Krueger read minutes of previous meetings regarding podiatry liaison clarification. On advice of Drs. Wolff and McDaniel the minutes were corrected to read "... the Committee was to study the advisability of changing the Blue Shield act to include the services of podiatrists." Mr. Krueger was instructed to write the podiatrists regarding this change. On motion duly made and seconded it was so voted.

MAG Board and Sub-Committee Reports

(a) BOARD OF LEGISLATION: J. Frank Walker, Chairman, made the following report:

(1) Arnold appointment: On motion duly made and seconded it was voted to appoint Maurice Arnold, Hawkinsville, to the Board of Legislation, at the request of the other Board members.

(2) State and National Sub-Committee appointments: Dr. Walker read a list of appointments to these two sub-committees, which had been approved by these Executive Committee. On motion duly made and seconded these appointments were approved.

(3) Legislative Board Actions: Chairman Walker read a list of Bills and Acts upon which the Board of Legislation had taken action with a view to recommending these to Council. Council approved all actions taken.

(4) Osteopathy: Chairman Walker and Mr. Moffett discussed MAG and AMA stands on Osteopathy. On motion (McKemie-Williams) it was voted to direct Dr. Walker to continue previous Association policy on Osteopathy and that the matter be brought before the 1962 MAG House of Delegates for re-appraisal in view of the 1962 AMA action, and that the Chairman of Council be empowered to write a letter pointing out to the Georgia Osteopathy Association this position.

On motion duly made and seconded it was voted to approve the Board of Legislation report.

(b) BOARD OF MEDICAL EDUCATION: Dr. Alexander gave the report for Chairman J. W. Chambers, who could not be present. On motion duly made and seconded it was voted to approve the report. Dr. Dillenger emphasized a Board decision on a proposed statewide Conference on Medical Education which would be scheduled at a later date.

(c) BOARD OF INSURANCE AND ECONOMICS: Chairman David R. Thomas gave a report on (1) Relative Value Study Sub-Committee recommendations that the California Medical Association Relative Value Study, as revised by MAG, be adopted. On motion (McDaniel-Simonton) it was voted to follow the recommendations of the Sub-Committee and accept the California Medical Association Relative Value Study as revised by MAG. After some discussion regarding the financing of this study, on motion (Walker-Simpson) it was voted to appropriate \$600.00 from the Contingent Fund, if needed, for this purpose. Also, on motion (Goodwin-Wolff) it was voted to ask the Relative Value Sub-Committee to get the information as soon as possible and come up with a coefficient as soon as possible for use by State of Georgia Employees Plan.

(2) MAG House of Delegates Resolution No. 3: Chairman

Thomas read the Resolution to Council regarding "Blue Cross Professional Services Coverage" for certain professional (Radiologists, Pathologists and Anesthesiologists) services. At a recent meeting the Board of Insurance and Economics had recommended that the Columbus, Atlanta and Savannah Blue Cross Plans be requested to cooperate in separating these services from Blue Cross. On motion (Wolff-Dillinger) it was voted to direct the Secretary to write the Blue Cross Plans in the above cities and protest the inclusion of these services in the Blue Cross contracts. On motion (Walker-Mercer) it was voted to request an answer and to inform Council of the replies to these letters.

The meeting was recessed at 6:00 P.M.

The Council meeting was reconvened at 8:25 A.M., September 17, 1961, at the King and Prince Hotel, St. Simons Island, Georgia.

Chairman Alexander asked Dr. Wolff to give his report on the Board of Governmental Medical Services at this time.

(d) BOARD OF GOVERNMENTAL MEDICAL SERVICES: Chairman Wolff gave a report on the recent meeting of this Board: (1) Divisions of Sub-Committees on Rehabilitation and Crippled Children into two Sub-Committees, one to be known as the Sub-Committee on Rehabilitation, and the other as the Sub-Committee on Crippled Children. On motion duly made and seconded it was voted to approve the division of the previous sub-committee into two. (2) Disaster Medical Care Sub-Committee: This Sub-Committee has proposed a statewide meeting on Civil Defense due to the world situation at present time. On motion duly made and seconded it was voted to ask the Chairman of the Board to appoint a committee to proceed with drawing up plans for an all-member meeting of MAG in regard to Civil Defense. It was also voted to approve the plan of the Board of Governmental Medical Services in regard to Civil Defense and to consider disaster medical plans for small hospitals.

(e) SUB-COMMITTEE ON CANCER REPORT—President Simonton reported on the present plan to pay 100 per cent hospital costs for indigent cancer patients. This would, therefore, deplete the funds as of January 1, 1962, of the State Aid Cancer program. On motion (Wolff-Simpson) it was voted that Council should authorize the Cancer Sub-Committee to proceed with plans to keep the cancer program operating as in the past, and that the Secretary be directed to write the Georgia Hospital Association expressing our concern and request cooperation to keep the cancer program going.

KERR-MILLS IMPLEMENTATION REPORT AND CORRESPONDENCE—President Simonton reported on the status of nursing home supervision under the Georgia Kerr-Mills implementation plan and other factors of the legislation.

A letter from the National Foundation was received for information.

A letter from John Bowen, Sandy Springs, was read regarding a meeting on School Child Health.

AMA BOARD OF TRUSTEES MEETING REPORT—Deferred until next Council meeting.

TREASURER'S REPORT—Dr. Arp's Treasurer's report was received for information. On motion duly made and seconded the report was approved as read.

ANNUAL SESSION REPORT—Mr. Krueger gave Council information regarding the 1962 Annual Session: (1) floor plan; (2) commercial and scientific exhibits; (3) scientific program; (4) addition of Medical-Legal Workshop to program. On motion duly made and seconded it was voted to approve the action of the Executive Committee in approving these plans.

NAM-HERLONG-BAKER TAX REFORM BILL — Mr. Moffett gave Council background information regarding the Herlong-Baker Tax Reform Bill. The NAM would like MAG endorsement of the Bill. On motion duly made and seconded it was voted to approve endorsement of the Bill.

Medicare Problems Regarding Complaints — Deferred MAG Headquarters Office Report

Mr. Krueger informed Council regarding employment of secretaries for Headquarters Office. He also mentioned the inactivity of some of the Association Boards. Other Headquarters problems were discussed.

Unfinished Business

(1) Appointment to Rural Health Sub-Committee: Upon resignation of Charles McArthur, Cordele, Chairman of the Rural Health Sub-Committee, Reid Gullatt, Cochran, was suggested as a replacement. On motion duly made and seconded his appointment as Chairman was approved.

(2) AMA House of Delegate Guest Speaker for 1962 meet-

ings: Executive Committee will designate the speaker at the meeting following this Council meeting.

New Business

(1) Letter to Governor Vandiver regarding State Board of Health appointments was read by Mr. Krueger.

(2) Nurses Conference with Georgia State League: This meeting is to be held in Augusta, October 9, 1961. On motion (Dillinger-Goodwin) it was voted that Walter Bloom, Atlanta, attend this meeting, and that Drs. Goodwin and Mercer would attend if possible.

(3) Interprofessional Council Letter: Georgia Pharmaceutical Association meets in October and November and has invited MAG Legislation Board members to these meetings, as well as the MAG Attorney. On motion duly made and seconded it was voted to refer this to the Legislation Board for decision.

(4) U. S. Chamber of Commerce Letter: An invitation to MAG to join the U. S. National Chamber of Commerce was received and a decision as to whether or not to join was requested of Council. On motion (McKemie-Brown) it was voted to continue our affiliation with the Georgia Chamber of Commerce and defer joining the National Chamber.

(5) Income Tax Automobile Expense Deduction: Vice President Lee Battle asked Council's opinion regarding a physician's automobile expense deduction. On motion (Wolff-Brown) it was voted to refer this matter to the Executive Committee for action, after the MAG Attorney has given the Executive Committee advice. A further motion duly made and seconded voted to expend funds not to exceed \$500.00 in supporting litigation, if such is necessary, and this be charged to Contingent Fund.

(6) Increase in AMA Dues: Dr. Wolff discussed the raising of AMA dues without due notice.

(7) State Board of Medical Examiners: Drs. Mercer and Walker discussed appointments to this Board.

(8) Professional conduct items were discussed.

(9) A letter of sympathy to Dr. Mauldin regarding his mother's death was discussed. It was recommended that the Chairman of Council write this letter.

(10) Date and Site of December Meeting: Dr. Eldridge invited Council to Valdosta and Dr. Dillinger invited them to Thomasville. On motion (Walker-Eldridge) it was voted to allow

the Executive Committee to make the decision as to location and date.

There being no further business the meeting was adjourned at 11:30 A.M.

EXECUTIVE COMMITTEE OF MAG COUNCIL MEETING

The meeting of the Executive Committee of Council was called to order at 11:30 A.M. by President and Chairman Fred H. Simonton, at the King and Price Hotel, St. Simons Island, Georgia.

Executive Committee members present were: Fred H. Simonton, Chickamauga, President and Chairman; Thomas W. Goodwin, Augusta, President-Elect; George H. Alexander, Forsyth, Chairman of Council; C. Raymond Arp, Atlanta, Treasurer; and J. G. McDaniel, Atlanta, Chairman of Finance. Also present were Mr. Richard Nelson, AMA Field Representative, Mr. Milton D. Krueger, Executive Secretary; Mr. James M. Moffett, Asst. Executive Secretary; and Mrs. Catherine Wooten, Executive Assistant.

AMA GUEST SPEAKER—Chairman Simonton asked for recommendations for the guest speaker for the MAG Annual Session on May 6, 1962. On motion (Alexander-McDaniel) it was voted to invite Hugh H. Hussey, Jr., Washington, D. C.; or Norman A. Welch, Boston, Massachusetts; or Wesley W. Hall, Reno, Nevada. It was suggested that the Secretary compose such a letter for the President's signature.

DATE AND SITE OF OCTOBER MEETING—October 15, MAG Headquarters, 10:00 A.M.

DATE AND SITE OF DECEMBER COUNCIL MEETING—On motion (Goodwin-Alexander) it was voted to accept Dr. Dillinger's invitation to Thomasville, with the dates to be December 9-10, 1961; also to thank Dr. Eldridge for his invitation to Valdosta.

AUTOBOILE TAX DEDUCTION—The Executive Committee asked the MAG Attorney to investigate this matter and report to Executive Committee at the next meeting.

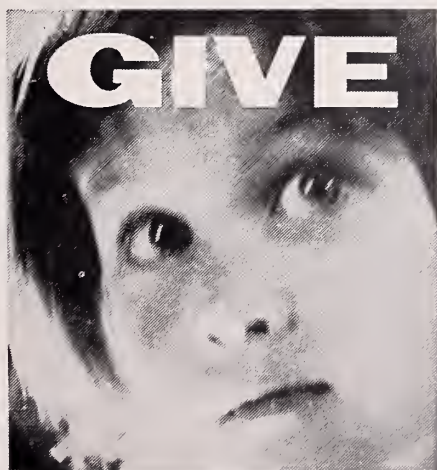
There being no further business the meeting was adjourned at 11:45 A.M.

Private Health Plan Soars In Great Britain

SINCE THE INCEPTION OF GREAT BRITAIN'S National Health Service, enacted by the Labour Party some 13 years ago, the country's largest private health plan has registered tremendous growth.

At the base year, 1948, the year of enactment of the NHS program, the British United Provident Association reported a membership of 65,000 persons. In slightly more than a decade this health plan is now providing private medical treatment and hospital accommodations, not available under NHS, for 850,000 Britons. This averages approximately 60,385 new members during each of the 13 years of the British socialized health service.

The general public of Great Britain is not alone in its disenchantment with the National Health Service. Members of the Labour Party themselves recently voiced dissatisfaction in a "white paper" devoted to the sad plight of the health system in Britain.



THE UNITED WAY

1961-62 CALENDAR OF MEETINGS

State

- Oct. 31-Nov. 2—Advances in Pediatric Diagnosis And Practice, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- Nov. 14-16—Fractures In General Practice, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- Nov. 30-Dec. 1—Annual Postgraduate meeting sponsored by the Department of Ophthalmology, Emory University School of Medicine, Grady Memorial Hospital Auditorium, Atlanta.
- Jan. 23-25—Obstetric Problems In Private Practice, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- Feb. 13-15—Cardiac Emergencies, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- Mar. 20-22—Pre and Postoperative Care, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- April 2-4—Augusta Postgraduate Medical Assembly (Coincides with practice rounds of the Masters Golf Tournament) Augusta.
- May 6-9—Annual Session, Medical Association of Georgia.**

Regional

- Nov. 4-5—Southern Chapter of the American College of Chest Physicians, Sheraton Dallas Hotel, Dallas, Texas.
- Nov. 6-9—Southern Medical Association, Municipal Auditorium, Dallas, Texas.
- Nov. 16-18—Southern Thoracic Surgical Association, Hotel Peabody, Memphis, Tennessee.
- Dec. 5-7—Southern Surgical Association, Hot Springs, Virginia.
- Mar. 2-5—Southeastern Surgical Congress, Louisville, Ky.
- Mar. 5-8—Southeastern Surgical Congress, Louisville, Ky.
- Mar. 12-15—New Orleans Graduate Medical Assembly, The Roosevelt Hotel, New Orleans.
- Mar. 18-21—Missouri State Medical Association, St. Louis.
- Mar. 26-28—American College of Surgeons, Sectional Meeting, Hotel Peabody, Memphis, Tenn.
- April 8-11—Tennessee State Medical Association, Peabody Hotel, Memphis, Tenn.
- April 26-28—Alabama, Medical Association of the State of, Tutwiler Hotel, Birmingham, Ala.
- May 5-9—Medical Society of North Carolina 108th Annual Meeting, Sir Walter Hotel, Raleigh.
- May 12-15—Texas Medical Association, Austin, Tex.

National

- Oct. 22-25—American College of Gastroenterology, Hotel Cleveland, Cleveland, Ohio.
- Oct. 22-27—American Society of Anesthesiologists, Inc., Statler Hilton, Los Angeles, California.
- Oct. 23-24—American Cancer Society, Biltmore Hotel, New York City.
- Oct. 23-27—American College of Chest Physicians, Postgraduate Course, Sheraton-Chicago Hotel, Chicago, Illinois.

- Oct. 25-29—American Society of Clinical Hypnosis, St. Louis, Missouri.
- Nov. 2-12—Second Postgraduate Medical Seminar Cruise through the Caribbean. (College of Medicine, University of Florida)
- Nov. 4-5—American Medical Association Conference on Disaster Medical Care, Chicago.
- Nov. 9-11—American Academy for Cerebral Palsy, Chase & Park Plaza Hotels, St. Louis.
- Nov. 11-13—Symposium on "Alcohol and Civilization," University of California Medical Center, San Francisco.
- Nov. 13-17—American College of Chest Physicians, Postgraduate Course, Park Sheraton Hotel, New York, New York.
- Nov. 13-17—American Association of Public Health Physicians, Detroit.
- Nov. 16-18—American Psychiatric Association, Hotel Schroeder, Milwaukee, Wis.
- Nov. 25-27—American College of Chest Physicians, Brown-Palace Hotel, Denver, Colorado.
- Nov. 25-Dec. 1—Radiological Society of North America, Inc., Palmer House, Chicago.
- Nov. 27-29—American Society of Hematology, Ambassador Hotel, Los Angeles, California.
- Nov. 27-30—American Medical Association, Clinical Meeting, Denver, Colorado.**
- Dec. 2-7—American Academy of Dermatology and Syphilology, Palmer House, Chicago, Illinois.
- Dec. 4-8—American College of Chest Physicians, Postgraduate Course, Statler-Hilton Hotel, Los Angeles, California.
- Dec. 7-9—New York Academy of Sciences Conference on the Cervix, The Barbizon-Plaza Hotel, New York City.
- Dec. 8-10—American Psychoanalytic Association, Biltmore Hotel, New York City.
- Dec. 9-10—Academy of Psychoanalysis, Hotel Commodore, New York City.
- Jan. 17-19—Tenth Postgraduate Course, American Diabetes Association, The Statler Hilton, Detroit, Mich.
- Feb. 5-7—American Academy of Allergy, Denver-Hilton Hotel, Denver, Colorado.
- Feb. 7-9—American Academy of Occupational Medicine, Pittsburgh-Hilton Hotel, Pittsburgh, Pa.
- Feb. 7-10—American College of Radiology, Roosevelt Hotel, New York, New York.
- Feb. 8-10—Society of University Surgeons, Cleveland, Ohio.
- Mar. 20-23—American Association of Anatomists, Minneapolis, Minn.
- April 1-6—American College of Allergists Graduate Instructional Course and 18th Annual Congress, Hotel Radisson, Minneapolis.
- April 2-14—Postgraduate course in Laryngology and Bronchoesophagology, University of Illinois College of Medicine, Chicago.
- April 2-5—American College of Obstetricians and Gynecologists, Palmer House, Chicago, Illinois.

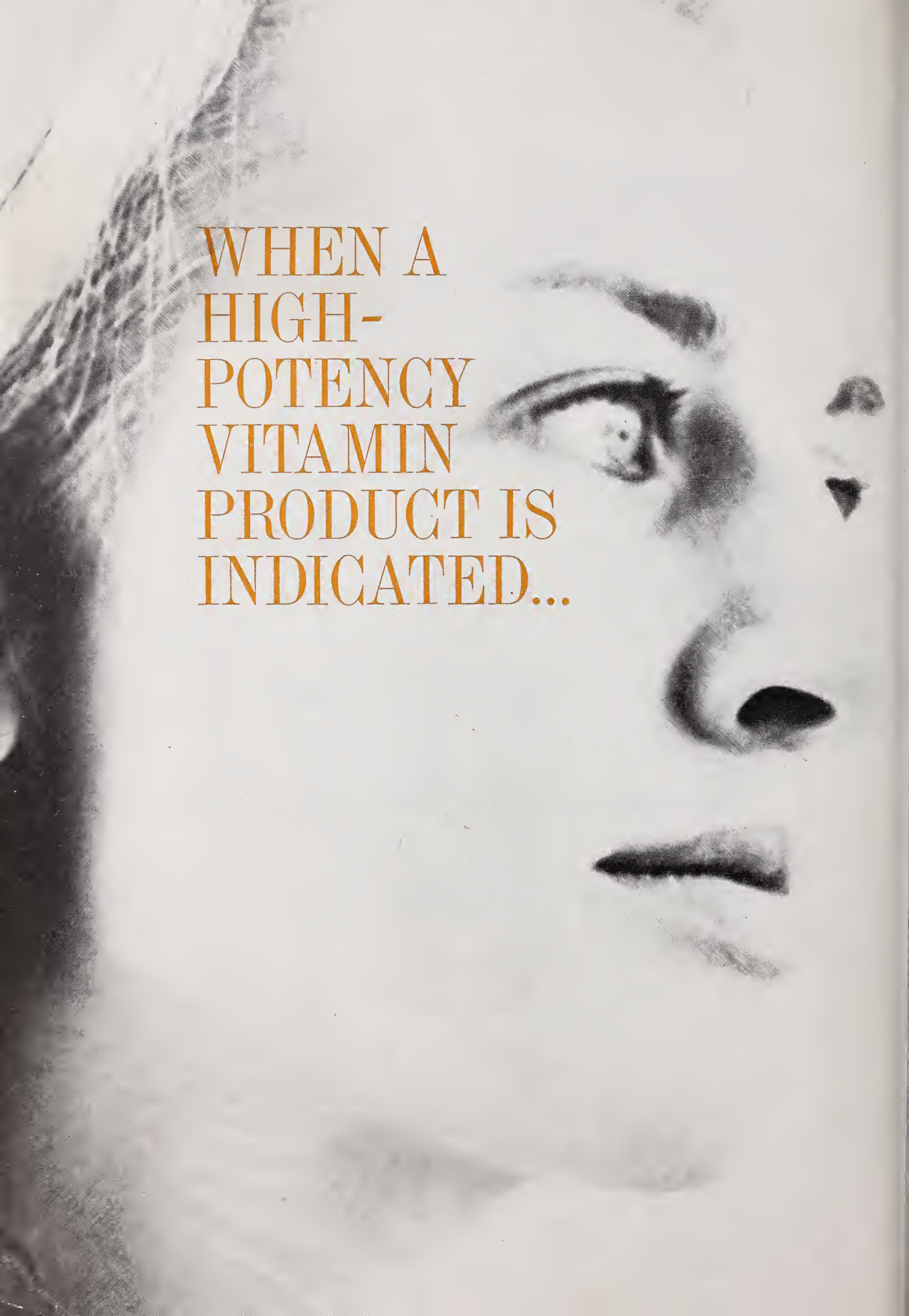
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"PSYCHOLOGIC REACTIONS TO PHYSICAL ILLNESS IN CHILDREN"

Barbara Maria Korsch, M.D., *New York, New York*

In many pediatric illnesses, the child's fantasies and imagined dangers may be much more disturbing to him than they would be in a more realistic understanding of the situation.

PHYSICAL ILLNESS IN A FAMILY produces a number of psychologic repercussions. Some of these are non specific. Like any other stress situation, illness tends to increase, exaggerate or make manifest the problems that already exist in a particular family situation. In addition to this, there are a number of specific psychologic consequences that may be attributed to the illness situation and in some cases are related to the specific illness or its treatment. There are three headings under which I will discuss some of these psychologic reactions to physical illness today. The reactions of the child, the parents, and of the physician.

The Child

Depending on the age of the child and the way in which he is handled, he will have different conceptions of what is the nature of his illness, what are its causes, and what he has to look forward to. It is amazing to me how often we, the physicians, and sometimes the parents, have no idea what an illness means to the child. This is unfortunate in many instances because the child's fantasies and imagined dangers may be much more disturbing to him than would be a more realistic understanding of the situation.

This has been investigated extensively in the case of hospitalization and especially surgery. The un-

realistic fear in relation to hospitalization that has been elicited again and again in the relevant studies, especially in younger children, has been the fear of abandonment by the parents. This seems to be present even in the absence of the still not infrequent misguided threats by parents and others caring for children to the extent of "if you are not good, I will take you to the hospital and leave you there." In regard to surgery, there are often fears of being "cut open," being mutilated, having something cut off. All of these misconceptions are probably most prevalent in children during preschool age when they play into some of the child's deeper psychologic development problems to which I will refer again a little later. When it comes to illness as such apart from hospitalization or operation, little systematic information is available, especially concerning the younger age group. The remarks I will make are based on a literature review and also on my own experience with sick children. For further study, I would recommend articles by Anna Freud* and Dane Prugh.*

One theme that runs through children's reactions to all illness and medical experience (again, most prevalent in the preschool age) is the feeling of guilt that is experienced by sick children in relation to their illness. A great many children when asked as part of a psychological test, "why do children get sick" answer "because they have been bad." A number of studies have shown that many diabetic

*Presented at the 107th Annual Session of the Medical Association of Georgia, May 8, 1961, Atlanta, Georgia.

PSYCHOLOGIC REACTIONS / Korsch

children believe they got diabetes because they ate too much sugar. Langford* described children with hemorrhagic nephritis who believed they caused their disease by masturbation. I could cite many more examples of this almost universal tendency. Obviously, this cannot always be elicited on short contact with a sick child, but if one is aware of the possibility that these feelings exist, one gets many indirect clues to their presence. For example, not rarely, a child will say that if he is good he may be able to get up tomorrow. Parents and health educators tend to reinforce these feelings in the child by making remarks like "if you go out into that rain you will catch a cold" or "you will spoil your eyes if you read in bad light" or "you will get sick if you eat so much candy." (Incidentally, not all these statements have a basis in fact.)

There are more deep seated psychologic mechanisms as well for the readiness with which children assume the burden of guilt for their own illnesses, and also for mishaps in others, but I will not take time to attempt to explain these now since I am surrounded by psychiatric colleagues who can offer you a more profound explanation. It is not appropriate to go into the details of psychodynamic theory at this time, but it is pertinent to remind oneself of a few of the basic psychosexual conflicts children experience usually in the years between two and five, traces of which stay active in all of us throughout adolescence and adult life.

Dependency on Mother

The infant starts his life almost completely dependent on his mother. Almost all his gratification and frustration develops in this relationship to the mother who feeds him and cares for him. As he grows older he becomes less passively dependent but all his newly developing emotions, some of which have an almost sexual flavor, will also develop in the framework of his relationship with his mother and later his father. His feelings for his mother are strong and possessive, and he resents any interference, be it from his father or his siblings. To understand the consequences of these feelings in young children, some of the other characteristics of the emotions of young children must be kept in mind. First, children's emotions are strong (just think of a three-year-old when he is angry). Secondly, they have little perspective and are still quite undifferentiated. Therefore, when they are angry, there is no control or ability to limit the emotion, "I wish you were dead, Mommie." Thirdly, they are animistic. They attribute to other people, animals, and even objects the same emotions that they have themselves. "Doesn't it hurt the grass if you step on it?" When

they see an adult angry, they assume that he must feel as overwhelmingly furious as they sometimes are. How does all this apply to sick children? It does in respect to the ease with which guilt feelings are aroused in them. They want their mother and, therefore, at times fantasy annihilation of the father. They wish their siblings out of the way. At times, they even get furious with the very mother on whom they are so dependent. All of this combines and convinces them that they are basically bad. Day to day minor infringements of rules of good conduct add to the guilty conscience. Thus, they become burdened by feelings of guilt and fears of retribution. On the basis of these feelings, they interpret a great many events of an unpleasant nature, including illness, as being well deserved punishment for them.

Control of Self and Environment

There is another basic psychologic need of young children that has relevance to the illness experience. The outstanding achievement of the years from infancy to early childhood is increased autonomy and mastery. The control of the self and the environment is a hard earned accomplishment which has not only practical but also emotional importance for the growing child. The illness experience threatens this achievement. Everyone (child or adult) regresses during illness. To the adult, this is usually not as upsetting because he is sure of his own powers. To the healthy young child, mastery, self care, and independence are still fairly new accomplishments of which he is protective and the loss of which arouses a great deal of anxiety. The regression due to illness is reinforced by the maneuvers of parents, nurses or caretakers that may be required in nursing a sick child and in giving the actual medical care. Being undressed and exposed, being bathed, being given medicine, having the temperature taken, physical examination, and the like constitute infringements on one's privacy, unwelcome to the adult, and very upsetting to the child.

There are two ways for the child to respond to these assaults. He may protest and wish to return to his former autonomy as soon as possible. (This is illustrated by the desire of the hospitalized child to get back his shoes.) He may gradually submit, becoming increasingly passive, infantile, dependent, and perhaps hypochondriacal. Which path is chosen depends in part on the personality makeup of the child and in part on the way in which parents and medical personnel handle the situation. One of the more specific stresses that is part of the illness experience is the fact that illnesses, especially chronic ones, require restriction of activity and movement on the part of the child. It is well known that the need for muscle movement and gross motor activities is one of the basic requirements (physically and

psychologically) for young children. This is easily demonstrated by observing a normal three-year-old in action or a class of second grade students emerging from the classroom after being restrained for a period of time. Motor activity furnishes acceptable outlets for all kinds of energies: aggressive, anxiety and sexual. If these outlets are not available, others (verbal, psychologic, and manual) must be utilized. Some of these are less wholesome than others.

Neuromuscular Disease

Psychologic studies on children with neuromuscular disease have shown their special problems in handling aggressive and sexual impulses. Animal experiments have demonstrated the possible consequence of movement restraints (weaving tic in horses and pacing of animals in the zoo). The inability to move freely affects the child's own image of his body. The way in which one's body is perceived (concept of body image) has important repercussions on psychologic development and most especially on the way in which the individual responds to illness. In moving parts of his body, the child learns about his own body and develops a healthy attitude and confidence in his own physical self. Movement restriction as in polio, arthritis, etc., radically undermines this confidence and makes the afflicted individuals more fearful of further injury, illness or other assaults on their physical health.

Most of the above factors are operative in many different illnesses. Certainly, they are more important in the case of chronic disease than in the occasional acute illness. On the other hand, if the usual milder infections and upsets that occur in the course of some children's early years are poorly handled, and if the child has a tendency to be overdependent, anxious, and hypochondriacal, psychologic development may be adversely influenced by repeated acute illness. A child who usually does not get enough gratification of his dependency needs may get to appreciate the secondary gains of physical illness and begin to fancy himself an invalid. In addition, there are certain features of specific illness that are especially upsetting to the child. Dietary restrictions which set him apart from the other children and also interfere with gratification in one of the most elemental strata of the personality are especially hard on the child with diabetes or allergy. The need for repeated painful procedures, enemata, catheterization, injections, repeated hospitalization with separation from parents at the time when they are needed most; the need for isolation from others as with tuberculosis in the old days which created kind of a "pariah complex" all of these are psychologically significant, and often these measures are interpreted as punishment by the child. Special developmental abnormalities and cosmetic defects which set chil-

dren apart from others become increasingly traumatic as the child gets older and probably take their greatest psychologic toll during adolescence when the whole question of measuring up to one's peers becomes paramount. Abnormalities affecting sexual development have been extensively investigated from the psychologic point of view and have proven of exceptional interest. Sensory handicaps, deafness, etc., impose specific psychologic conflicts. Heart diseases and other conditions requiring bed rest and restricted activity without obvious explanation may seem very ominous to young children.

The Parents

In addition to demonstrating the particular effects of illnesses on young children, all the observations of others and our group emphasize the fact that the child's attitude toward his illness, toward the treatment of the illness, and toward his own body reflect in large measure the attitude of his parents and/or the other crucial adults in his life. If the parents are overanxious or have the need to keep their children passive and dependent, illness provides the occasion for these attitudes to be demonstrated and magnified. Thus, again, illness serves as a nonspecific stress experience for the family which brings into relief relationships that are characteristic of a particular family rather than of a specific disease. We are all familiar with instances in which a family reacts to a child's minor illness as if it were a major catastrophe, and by their own attitude toward the child, give him a feeling that he is an invalid. In some families, the fact that the doctor states once that a child has "slight heart murmur" is sufficient to set in motion a whole chain of psychologic events. The child may be restricted in his activities. Attempts are made to protect him from stressful experiences. He is kept away from other children for fear of his being exposed to infection. Disciplinary measures are waived for fear that frustration and anger may constitute a "strain on the heart." The end result is that the child considers himself severely handicapped, acts accordingly, and also becomes something of a spoiled brat. There are other children who suffer from a severe physical handicap or disease but are treated by their families in such a fashion that their conception of themselves as a member of the family group and in relation to other children in school and community is basically wholesome. There is almost universal agreement among students of this subject on this point. Severe handicaps such as deafness and blindness interfere with personality development to the degree that the parents' attitudes about the defect are transmitted to the child and to the degree that he is limited in his developmental and social outlets. In cerebral palsy, and similar conditions, the success of rehabilitation depends on the attitude of the fam-

ily and the child more than on the exact nature of the handicap. Severe anomalies of a major type such as adrenogenital syndrome do not necessarily have to lead to major maladjustments. On the other hand, cryptorchidism, hypospadias or even small sized genitalia in children of families overconcerned with the abnormality may leave the patient with an emotional conviction that he is deformed and a freak. Examples of this are found among the boys with cryptorchidism whose mothers very often are sure they will be homosexuals. In our own work with parents of children with nephrosis and diabetes, it was demonstrated again and again that the presence of the same disease state means very different things in various family situations. In the diabetic, for instance, the severe behavior problems occurred in those children whose parents were most overwhelmed with anxiety, guilt, and self blame concerning their child's illness. Overconcern with food and diet in the children leading to obesity or unnecessary food restriction, occurred in those families where the parents, especially the mothers, were emotionally too involved with food and eating. Struggles regarding injections were most rampant in the home where the mother or father was unable to accept objectively that these were necessary and not catastrophic. If we agree, as I think we must that the parental attitude is the single most important factor in determining the child's own attitude toward his illness and toward himself as a person, and in the likelihood of optimal adjustment or recovery, we then become concerned with the determinants of these parental attitudes. We also need to know what can be done to influence them favorably.

Important Determinants

The most important determinants are unfortunately beyond our reach at the time when we confront the sick child. The family with their own childhood experiences, basic personality problems, and preoccupations with bodily illness or injury is already established. But, I do believe that the more aware one is of the existing personality traits and problems, the more helpful one can be in creating optimal psychologic conditions for the child in cooperation with the family. The two main feeling states in the parents of the sick child, as in the child himself, are anxiety and guilt. The anxiety is only in part realistic and in large measure depends upon psychologic mechanisms. The guilt feelings that are universally encountered in the parents of sick children can be accounted for only by looking back into their own childhood experiences and into the layers of their emotional makeup which are beyond the scope

of this discussion. Suffice it to say these guilt feelings have profound effect on the way in which parents handle illness in their children. Very rarely is there out and out rejection of the sick child. Much more commonly the parents have the need to overcompensate, "make it up to the child," and to overprotect the child who is ill. This has adverse effects on other family relationships, siblings, and the marriage.

The Physician

What can the physician do to influence parental attitudes favorably and to deemphasize anxiety and guilt feelings? Quite a lot, I think. There are many avoidable, preventable ways in which physicians contribute to parental anxiety. For instance, the manner in which the medical history is taken and comments by the doctor such as "why didn't you call the doctor when you first noticed he seemed to be limping?" or "have you taken him to any crowded beaches in the last couple of weeks?" may reinforce self blame for the child's illness in the parents' mind. Admonitions such as "take it easy," "don't smoke too much," "no heavy work," if they are insufficiently explained may make the mother who gives birth to a baby with a congenital anomaly wonder whether perhaps she did not take it easy enough, smoked too much or did work that was too hard.

Some physicians are more direct in contributing to the assumption of blame by parents of sick children. For instance, "you should never have allowed him on the street alone. That is very dangerous" or "didn't you know that it is hazardous to give a laxative to a child with a belly ache?" Even if these statements are medically right, they should not be made at the moment when parents are distressed over illness in their child and need reassurance and support. If the physician has a reassuring and supportive manner with the parents, they in turn will be able to be protective and supportive to the child. The more their own anxieties are aroused, the more these will rub off on the child patient. Some physicians always seem to have patients who are "on the verge of pneumonia" or have a "touch of appendicitis" but are just saved by the excellent care given by these doctors who are called "just in time." This kind of physician needs to make his patients dependent and makes himself look good at the expense of the parents' peace of mind.

Another common fallacy consists of inflicting one's own anxieties as a physician on the parents to an undue degree. Medicine is a field in which decisions must be made even though the evidence may not all be in. Although parents are becoming increasingly knowledgeable and interested in medical matters, they should not be expected to share our uncertainties and anxieties about the patient unless this is required

in order for them to comply with medical treatment or unless major decisions have to be made by them. Examples of this kind of psychological error in medical management are easily found (e.g., management of patient with febrile convulsion) but for now I will turn to some of the therapeutic potentialities of the doctor-patient relationship. First of all, the very existence of a good relationship with the family doctor or pediatrician is tremendously reassuring to parents. Just think how much more comfortable you are if your car breaks down when you are near a trusted familiar garage than if it happens away from home when you do not know where to turn. Secondly, the doctor's willingness to listen to just what has been the illness experience for the child and the family, to take time to let himself be told that the baby has thrown up every single feeding in the 24 hours since the fever started is necessary in order to convince the mother that he really

understands and knows her problem, and that his reassurance and advice "not to worry" are not given lightly. Thirdly, his careful listening combined with an awareness of some of the known psychological ramifications of physical illness (*vide supra*) will also alert him to specific misconceptions, guilt feelings, etc., that he may be able to dispel. Fourthly, alertness to the need for activity and self mastery in a young child will prompt the doctor to permit and encourage maximal freedom of movement and self care for the child. Finally, he can support the parents in all efforts to relieve anxiety in the child and with their help do everything in his power to prevent excessive invalidism. He can also encourage approaches (other than overprotection) which help the parents to compensate for their feelings of self blame in relation to the child's illness (e.g., participation in child's care).

AMERICANS SPEND LARGER PORTION OF INCOME ON HEALTH SERVICES

Americans are spending an increasing portion of their income on health services and this trend will continue, according to George Bugbee, president of the Health Information Foundation.

Writing in the September 1 issue of *HOSPITALS*, Journal of the American Hospital Association, Mr. Bugbee reported that the annual expenditures for all types of medical care have risen from \$3 billion 30 years ago to \$25 billion today. During this period, he said, private expenditures for hospital care have risen from \$400 million to \$5.5 billion, representing approximately 30 cents of each dollar spent for medical care today.

He explained that the increase in hospital expenditures is in part due to an increase in the unit cost of a day of care, which has risen 340 per cent since 1940. "The unit cost of a day of care and the insurance coverage for hospitalization which reflect the increase are the fastest rising items in the medical price index," he said.

Future expenditures for medical care will inevitably be greatly affected by our expanding population which is expected to reach 235 million by 1975, Mr. Bugbee said, adding that the growing number of people over age 65 account for approximately nine per cent of the population.

The upward trend of chronic illness in later life will mean even greater expenditures for medical care, Mr. Bugbee asserted. A recent survey spon-

sored by the Health Information Foundation showed that 34 per cent of all families reported at least one member seeing a physician for a chronic condition; but this figure jumped to 69 per cent among families with medical expenditures of \$1000 or more in a given year.

Mr. Bugbee predicted a continued trend toward greater utilization of hospital facilities. He observed, "During my generation, the care of obstetrical patients has moved from home to hospital, and there is also a movement from home to hospital for the last days of life. Deaths in general hospitals have increased in the last 20 years from 34 to 48 per cent of all deaths."

Changing patterns of illness are focusing greater attention on the need for thoughtful planning of new health facilities. While alarm has been expressed in the past over the possibility of overbuilding hospital facilities, Mr. Bugbee said, "the question is more nearly one of quality or type than sheer quantity." He predicted, "We will certainly see fewer but larger hospitals. . . ."

One of the unresolved questions in hospital facility planning, Mr. Bugbee pointed out, is that whereas the population growth has been suburban, "the largest and best hospitals have developed in central cities. Our most valuable research and educational activities have also tended to be in central cities; yet we see a trend toward decentralizing the hospital physical plant."

REPAIR OF SOFT TISSUE WOUNDS OF THE FACE

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*Some illustrative examples
in the author's experience are discussed.*

THE SOFT TISSUES of the face are very similar to the soft tissues of the body elsewhere. However, because of the specialized functions of various parts of the face and because of the premium which society puts on the pleasant appearance of the face, these injuries assume great importance. This brief paper will avoid for the most part side issues such as the general care of the patients, the treatment of infection, the prevention of rabies, tetanus, etc. and the specific treatment of skeletal injuries in an attempt to concentrate attention on commonly seen injuries handled to a large extent by the first doctor who sees the injured patient. One would not argue that in the more complicated injuries, the patient is best referred to a specialist in their repair, but often times this is not practical and general principles of immediate repair should be familiar to any physician seeing the injured patient.

The treatment of the injured patient and injured tissue, of course, will depend to a great extent on the degree of the injury, the type of injury (that is to say the mechanism of injury and the traumatizing agent) and, of course, the location of the injury.

The simple laceration may leave a scar as noticeable as a deep penetrating or partially avulsed wound if not handled correctly. General principles of treatment consist of thorough cleansing, debridement as indicated, and careful layer repair. In brief, cleansing consists of the removal of all foreign material from the wound, thorough cleansing of the skin about the wound, and tedious irrigation and cleansing of the wound itself. In cleansing the wound one should avoid the use of agents which are injurious to tissue, such as strong antiseptics.

Most commonly it is suggested that a soap and water cleansing of the surrounding skin and irrigation of the wound should be followed by an irrigation with normal saline or hydrogen peroxide. Phisohex and similar detergents have become quite popular for use as cleansing agents and may be followed by thorough irrigation of the wound to remove not only the detergent but the blood clots and any foreign material which may have entered the wound.

Debridement should be minimal to none at all for simple clean lacerations and should be conservative in all instances, removing only the tissue which is devitalized to the extent of delaying wound healing. Obviously, ragged wound edges should be trimmed to give clean incised edges. Tiny loose bone fragments may be removed from the wound but fragments of any size may be thoroughly cleansed and returned to their proper site in the wound to furnish skeletal healing and support.

The layer repair should be carried out using snug sutures without strangulating the tissue, and as many layers are closed as considered necessary to give a nicely closed wound leaving no dead space. The choice of suture material will vary with the operator, but plain catgut buried sutures are always satisfactory. It is preferable that small sutures be used, avoiding large suture material which also leaves large knots when tied. When sutures are placed near the wound surface, they should be inserted in such a fashion that the knot will assume its place deeply in the wound rather than just beneath the skin surface; in other words the knot is inverted by inserting the needle deeply but toward the surface and then looping through the superficial area back deeply to tie the knot. Nonabsorbable sutures may be used quite satisfactorily, and my own preference is white twisted

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nylon suture material of about 5-0 size. This may be sterilized by boiling and small curved cutting needles are used for their insertion. Plain catgut of size of 3-0 and 4-0 are quite satisfactory.

The skin closure itself may be carried out in several ways. If one is experienced in the use of the running subcuticular or intracuticular suture, this gives a snug closure with everted edges and good approximation. The suture may be left in place without danger of suture marks giving an extended period of support to the wound edges. This suture technique is a useful one and usually requires the use of single filament nylon or polyethylene sutures. In certain instances when support is needed for only a very brief time (as in the eyelids) small plain catgut may be used in this fashion. If one is not experienced in the use of the subcuticular suture, it would be best to use a suture technique with which he is familiar. If one is very careful to place the sutures perpendicular through the skin and close to the wound edges, one may achieve good approximation and nice eversion by the use of interrupted sutures of 5-0 or 6-0 black silk. To avoid stitch marks one should avoid tying these sutures tightly and should remove them early. Always one should avoid strangulating tissue. A good result may be achieved by using a close running suture of over and under 5-0 or 6-0 silk in a similar fashion. With a little experience one may get equally good results as when interrupted sutures are used and yet may save considerable time using the fine running suture.

It has been found that large sutures are much more likely to leave stitch marks, but most important is the length of time the sutures are left in place. If small sutures are left in place no longer than three or four days it is very unlikely that permanent stitch marks will result. An exception to this is when infection occurs about the stitches or when they are tied so tightly as to cut into the tissue. The increased danger of tying sutures too tightly with larger suture material is obvious. Naturally finer suture material does not allow for tight tying which would result in strangulation of tissue.

Avulsed Wound

The ragged type of wound presents very few additional problems over the clean incised wound. In managing this wound one should achieve as near as possible clean incised wound edges which will allow for good approximation of viable tissue and viable wound edges. Debridement should be carried out only in so far as is necessary to achieve this result. Avulsions of tissue may be partial or complete. In partial avulsions involving the face, one is frequently surprised at the adequate blood supply which still remains to the tissue. Frequently, only

minimal debridement of the edges allows a replacement of the tissue with very adequate healing because of the very rich blood supply to the face.

In those avulsions of skin which are almost complete and without adequate blood supply, or in clean complete avulsions in which the tissue is recovered, one may use this tissue up to several hours after the accident by trimming and thinning to use as a full thickness graft, replacing it in the area from which it was torn or cut. There is no substitute skin from any area of the body, no matter how good, which equals that of the face itself. Therefore, a graft of the tissue which is removed replacing it in the area from which it came is always worth considering, unless it is badly contused or contaminated. However, when substitutions are necessary, full thickness grafts should be taken from the base of the neck in the supraclavicular area or smaller ones from the post-auricular area. Skin from these two areas has the texture and color more nearly matching that of the face. In either area fairly large grafts may be removed with primary closure of the wound, leaving only a linear scar following the lines of the skin of the neck or along the crease at the junction of ear to scalp.

Thermal Injuries

Should the wound be a thermal injury with destruction of tissue, one would not choose a primary repair using a full thickness graft, but most likely would repair the wound as early as tissue recovery allowed using a split thickness graft from the buttock. Later, when tissue recovery has reached the point of softening, this may be replaced by a full thickness graft for better color and texture match. In areas of deep injury and great tissue loss requiring replacement of subcutaneous tissue as well as skin, a flap from the neck or chest will furnish skin and subcutaneous tissue. These flaps require multi-staged delaying procedures, except for simple rotation flaps which at times may be carried out using skin from below the jawline area of the neck onto the cheek or chin.

Lacerations and avulsions in certain areas of the face present particular problems. Through and through wounds of the eyelid, lip nostril or ear require very careful approximation of the different layers. This is frequently accomplished by using figure-of-eight sutures which may be tied back of the ear, inside the nostril, beneath the eyelid, or beneath the tip. The figure-of-eight suture may incorporate, in the case of the lip, the deep musculature and the mucosa beneath the lip leaving only a simple closure of the skin on the outside surface to finish the repair. A subcuticular a running or interrupted suture technique may be used as long as sutures are

removed early from across the wound. Figure-of-eight sutures may be left in place for extended periods to give proper support. The same technique is useful for the other areas mentioned, and in each instance one should be particularly careful to achieve, not only approximation of tissue, but perfect alignment of the structures. The margin of the ala of the nose, the margin of the eyelid, the vermilion border of the lip, and the margins of the ear should be very carefully approximated to avoid notching, unevenness, and obvious deformity. Alignment of tissue is always important but is especially important in these areas, as well as in the edges of the hairline, the eyebrow, and across cleavage lines and creases. The choice of suture materials for the figure-of-eight suture is similar to that of the subcuticular suture, single filament nylon or polyethylene usually proving best.

It has been mentioned that each severed layer of tissue should be repaired carefully to give the wound a complete repair, avoiding dead space and equalizing the thickness of the tissue at the site of injury with that of the surrounding tissue. One might mention also that any severed tissue of specialized function should be repaired as carefully as possible. Severed nerves and vessels of any size should be repaired whereas small vessels may be simply ligated or clamped carefully for a few minutes to allow for their sealing. Structures such as the facial nerve should be repaired primarily except in dirty contaminated wounds, in which case one might elect to approximate loosely by through and through black silk sutures left for identification purposes with the idea of going back secondarily to do a more careful repair. The parotid duct should be repaired to avoid a draining sinus.

Though this is primarily concerned with soft tissue wounds and their repair one cannot overlook the importance of the underlying skeletal support of the tissues. Frequently one must first repair the underlying supportive tissues as in the case of fractures of the jaw, depressions of the maxilla or zygoma, of comminuted fractures of the nasal bones, zygoma, maxilla, and including the orbit. Quite obviously comminuted fractures of the facial bones must be reduced and supported by wiring or by packs beneath the fragmented bone to give support until healing has made a firm start. After attention to the skeletal injury, and at the same sitting, the overlying soft tissue may be properly repaired.

As in the case of soft tissue injuries, one might expect to have to do secondary procedures in some of the more severe injuries both to the skeletal supporting tissues and to the soft tissue itself. Bone

grafts and cartilage grafts to support the nasal bridge and tip or to build up the orbital margins and support the orbital contents may occasionally be required. The soft tissue itself cannot be expected to heal as well when subjected to extensive trauma as when one very carefully severs the tissue with a sharp scalpel as in doing elective surgery. Likewise, one would expect a better result by careful excision and gentle repair of tissues than after original repair of the traumatized tissue. Therefore, when scars are unduly noticeable, depressed, adherent, or hypertrophic, surgical excision and repair is indicated. This secondary repair of scars may be combined with or followed by the further smoothing and blending of the scars by surgical abrasion. This has been a useful adjunct in minimizing scars.

Post-Operative Care

Whether at the time of the original injury or at the time of the secondary repair, post-operative care of the wound is of great importance. A snug pressure dressing is desirable in many instances to minimize edema in the wound, to prevent collection of fluid and hematoma, and to give support to the tissue and avoid pulling and stretching on the approximated edges. In certain areas as in injuries to lips and to eyelids, one may elect to use cold compresses for 48-72 hours following the injury instead of using snug pressure bandages. In this case, the cold minimizes pain as well as swelling and may be useful in minimizing tissue need for blood supply and oxygen in instances of precarious blood supply following partial avulsions. When wounds are left open and cold compresses are used an antibiotic ointment may be used lightly on the suture line itself to minimize the chance of contamination. The early removal of interrupted and running sutures across the wound is followed by supportive dressings using flexible collodion or small adhesive butterfly strips. In the use of subcuticular or figure-of-eight sutures tied out of sight away from the skin surface (such as beneath the lip or inside the nose) the sutures may be left for a longer period of time for support. Ten days or two weeks will be adequate, and where there is little tension on the skin, an even shorter period of time.

This would seem a rather elementary and fundamental group of remarks with little claim to originality. However, one cannot over estimate the importance of careful repair of wounds about the face. The social, economic and psychologic aspects of these wounds will remain to plague the patient. The physician owes it to himself and to his patient to do his utmost to minimize such deformity.

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J. M. A. GEORGIA



Figure 1A

What Not to Do—Note the large suture material tied tightly across the wound, the sutures having been left in place too long, and with improper debridement of original wound.



Figure 1B

Note very prominent stitch marks extending out from scar.

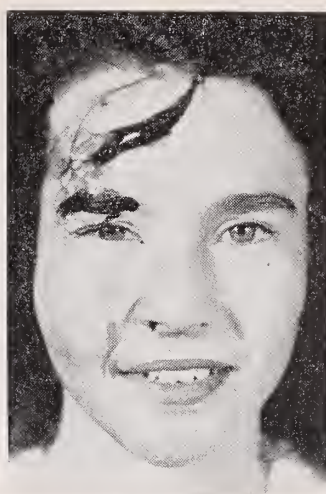


Figure 2A

Rather clean incised laceration extending obliquely across forehead and across lines of the skin.

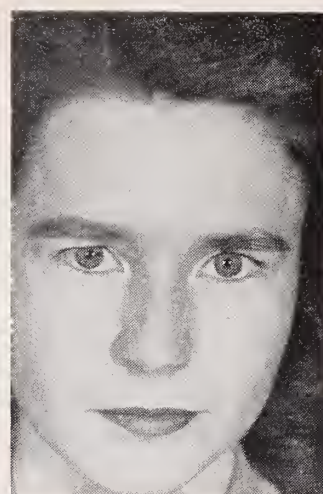


Figure 2B

Note very fine line scar with smooth surface resulting from careful layer closure and the early removal of skin sutures.



Figure 3A

Stellate laceration of left eyebrow and eyelid through and through upper lid.



Figure 3B

Following surgical repair of eyelid and eyebrow area—note small bald area in eyebrow.



Figure 3C

Following simple excision of bald area and approximation of hair bearing areas of eyebrow.



Figure 4A

Deep wound of cheek, following layer repair except for skin closure. This is the way a wound should look before the skin sutures are put into place. This shows the simple need of skin sutures to evert the edges, but the lack of any real need for support.



Figure 4B

Following insertion of 6-0 silk interrupted sutures. These are removed in two to four days without permanent stitch marks. Following this the wound is supported by flexible collodion for seven to 14 days.



Figure 5A

Multiple extensive deep avulsions and lacerations, eyelid, cheeks, nose, etc.



Figure 5B

Following repair and following secondary excision of scar vertically across center of forehead. This shows subcuticular (intracuticular in many instances) suture of skin proper after approximation of deep tissues. The subcuticular suture may be left in place for two or three weeks without suture marks in a wound with tension on the edges.

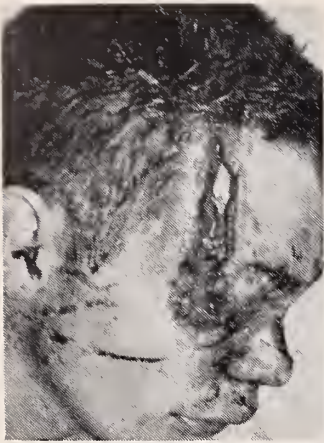


Figure 6A

Extensive ragged laceration — avulsion of scalp, forehead, temple, upper and lower eyelids and destruction of eye bulb.



Figure 6B

Following more extensive debridement to sharp cleanly incised healthy tissue, thorough cleansing, and repair in multiple layers of the divided tissue. Also use of avulsed skin of lower eyelid which was replaced as full thickness skin graft. Also artificial eye has been put into place.



Figure 7A

Extensive avulsion of scalp and forehead revealing bare bone of whole top of the skull.



Figure 7B

Following replacement of large narrow pedicled flap, and split thickness graft over area of right temple and frontal area not covered by replacing the debrided flap.



Figure 8A

Complete avulsion of skin from bridge, tip, alae and columella of nose and from part of upper lip.



Figure 8B

Following immediate repair by full thickness skin graft from supraclavicular area of neck. In time this graft will blend very satisfactorily with the normal skin of the nose and lip.



Figure 7C

The scalp flap and split thickness graft are shown well healed revealing the very rich blood supply to the face and scalp which allow replacement of tissue which would be very precarious in other areas of the body.

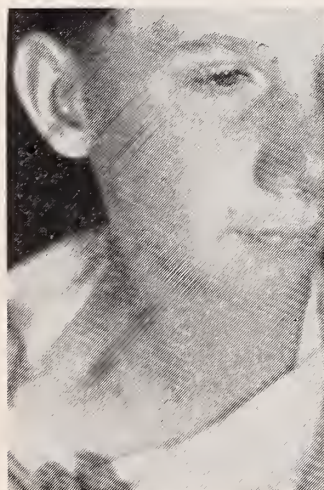


Figure 8C

Showing the minimal linear scar in the supraclavicular area of the neck. This wound was closed primarily after removal of the full thickness graft to replace the tissue loss of the nose and lip.



Figure 9A

Extensively comminuted fractures of zygoma, maxilla, nasal bones, and markedly depressed and comminuted infraorbital support, and transverse fracture across whole maxilla with drop posteriorly and inferiorly of whole maxilla, along with extensive lacerations of the cheeks, nose, lip.



Figure 9B

Following immediate repair of soft tissue wounds and extensive wiring of larger fragments of maxilla, zygoma, temporal bone, and by support of the right maxillary sinus by intra-antral packing and intra-nasal packing and splinting for support of nasal bones. Note drop in level of right eye because of loss of infra-orbital support. Also drooping of eyelid and cheek because of partial right facial paralysis due to injury to branches of facial nerves.



Figure 9C

Following support of right lower eyelid by fascia lata strip, build up of infraorbital support, corrective rhinoplasty with narrowing and raising of nasal bridge and tip, and excision and repair of cheek and lip and nose scars where needed. Note that the eyes are now looking from the same level as evidenced to the patient by the correction of the double vision.

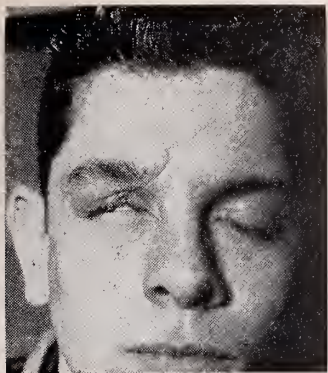


Figure 10A

The responsibility of the surgeon still remains following the healing of wounds, and secondary repair of scars with contractures and deformities should be considered a part of the rehabilitation of the patient. Note oblique scar obliquely across forehead and eyebrow area and with contracture and deformity of upper lid.

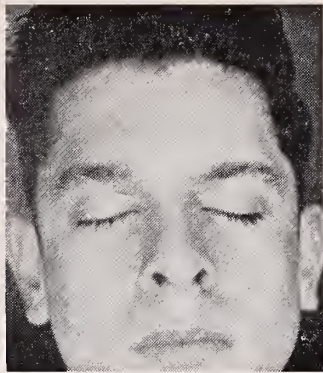


Figure 10B

Following z-plasty beneath eyebrow, excision and repair of scar of forehead, full thickness graft from base of neck to upper lid.



Figure 11A

Note obvious scar of temple and cheek extending across the external canthal creases making the tightness there quite obvious.



Figure 11B

Following excision and repair of scar in multiple layers along with z-plasty opposite external canthus to blend the scar into the normal creases and break up the straight line scar pull.

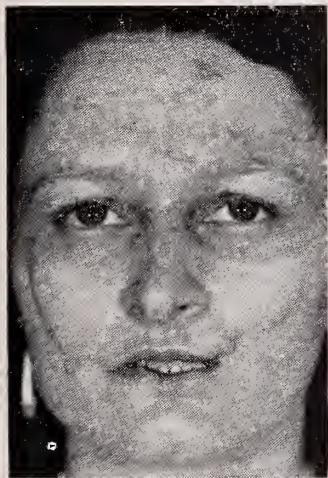


Figure 12A

Multiple scars from through and through lacerations of cheek and lip and multiple partial ovolutions of forehead, along with complete ovolution of area of center of lower lip.



Figure 12B

Following surgical excision of multiple scars, the excision of defect of lip with repair in multiple layers and surgical abrasion to blend out the various scars following their repair.



Figure 13A

Traumatic tattoos and scars of upper and lower lip, tip of nose and area of left cheek following fall from bicycle in cinders.



Figure 13B

Following surgical abrasion of foreign material from these areas, but still showing some redness from the recent procedure.

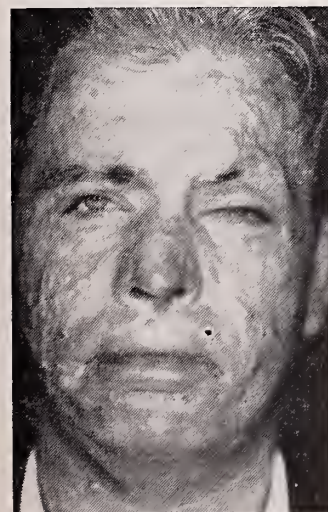


Figure 14A

Severe hypertrophic burn scars of the face causing ectropion of upper lids and loss of left eyebrow and part of right eyebrow, and marked hypertrophic scarring.

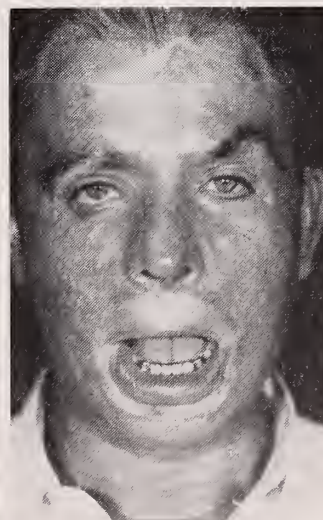


Figure 14B

Following surgical abrasion lightly to blend out scars of whole face, reconstruction of left eyebrow from scalp, and center of right eyebrow, full thickness grafts from inside of thigh to upper and lower lip and adjacent areas of cheek. Note the marked difference in color of the full thickness grafts about the lips and mouth as compared to the very ruddy skin of the cheeks. This was replaced by full thickness grafts from the neck.



Figure 14C

Note much better skin match of full thickness grafts about the mouth as taken from the neck. These are hyper-pigmented at this time, but gradually blended into the normal skin so as to be less noticeable with passage of time.



Figure 14D

Note well healed full thickness graft up upper eyelid correcting the ectropion and the well developed and luxuriously growing eyebrow reconstructed by a free full thickness graft from the scalp.

DIABETES AND PREGNANCY

Buris R. Boshell, M.D., *Birmingham*

The stress of pregnancy frequently reveals the presence of latent diabetes.

PREGNANCY HAS LONG BEEN recognized to have a different course and outcome in the diabetic as compared to the non diabetic; however, prior to the availability of insulin, the incidence of pregnancy in diabetic patients was so comparatively low that the problem was not as apparent as now. Williams reported only one instance of pregnancy in a diabetic during his first 13 years as head of the obstetrical department at Johns Hopkins¹. The deviations from normal which are most frequently noted in pregnant diabetics consist of an increased incidence of the following: 1. Previaible losses (abortions) 20 per cent, 2. Perinatal deaths 45 per cent, 3. Toxemia 33 per cent, 4. Congenital fetal abnormalities and 5. Hydramnios 100 per cent^{2,3}. Careful regulation of the diabetic state during the pregnancy with adequate diet and insulin markedly decreases the incidence of the aforementioned complications but does not appear to return them to the levels noted in non diabetic controls^{4,5}. According to Tolstoi the mortality rate among viable fetuses (28 weeks or older) of diabetic patients under reasonable control is however generally less than 25 per cent in most clinics⁶.

The problems of diabetes in pregnancy will be discussed under the following headings:

1. Diagnosis of diabetes during pregnancy.
2. Hormonal aspects of pregnancy.
3. Infection during pregnancy with special references to the urinary tract.
4. Management of the pregnant diabetic.

Diagnosis of Diabetes in Pregnancy

Diabetes is frequently first diagnosed during pregnancy. Figures for the number of cases of diabetes

discovered during pregnancy in relation to the total number of pregnant diabetics have been reported by Bowen and Heilbrun⁷ as 27 per cent, by Herrick and Tillman as 27 per cent⁸, by Lawrence and Oakley as 18 per cent⁴, by Rike and Fawcett as 28 per cent⁹, by Barns and Morgans as 22 per cent¹⁰ and by White as 57 per cent¹¹.

Thus the stress of pregnancy frequently reveals the presence of latent diabetes. If the disease is severe enough to cause prominent symptoms of polyuria, polyphagia, and polydipsia or come then there is no problem in making the diagnosis. Unfortunately from the diagnostic standpoint however, the manifestations of diabetes that first appear in pregnancy are mild and may be confused with renal glycosuria and/or lactosuria which are frequently found in pregnancy. Renal glycosuria of pregnancy is usually first observed between the third and fifth months of gestation and may occur in the normal as well as the diabetic patient¹². The etiology of this glycosuria is postulated to be due to a lowered renal threshold for glucose caused in part by the effect of adrenal steroids, which are produced in greater quantities during pregnancy, on the renal tubules¹³. The actual incidence and importance of this so called "renal glycosuria of pregnancy" is open to question. Williams and Wills found a 5.4 per cent incidence in 640 pregnant women¹⁴. Lepin stated that 40 per cent of all pregnant women exhibit glycosuria at some time during gestation¹⁵. These authors believed the glycosuria to be benign and unimportant. Duncan, however, states that pregnant women with glycosuria should be watched for an indefinite period following delivery as diabetic suspects¹⁶. Batilwalla found that the incidence of glycosuria rose from about five per cent during the third month of pregnancy to 40 per cent during the ninth month¹⁷. Other investi-

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gators have also reported an increased incidence of glycosuria during the second and third trimesters of pregnancy¹⁸. The glycosuria of pregnancy disappears abruptly after delivery and none is usually found by the eighth post partum day unless true diabetes mellitus is present. A glucose tolerance test is usually necessary to determine the significance of glycosuria. Lactosuria occurs during the last six weeks of pregnancy in approximately seven per cent of cases¹⁹. It is found in 100 per cent of specimens on the third and fourth post partum days²⁰. Actually by careful paper partition chromatography Flynn found lactose in nine per cent of control urines from males and non pregnant females and in 50 per cent of the urines from pregnant females²¹.

The glycosuria found in pregnancy should probably be considered as indicative of diabetes mellitus until proven otherwise by glucose tolerance testing. Even in the presence of an associated normal glucose tolerance test the patient should be followed. Miller studied 137 pregnant women, 11 of which showed glycosuria but a normal glucose tolerance test²². Four fetal deaths occurred in these 11 pregnancies and three of the infants weighed over five kilograms at birth.

Crampton states that normal women show no decrease in glucose tolerance during pregnancy and that an abnormal response to glucose tolerance testing is indicative of diabetes or prediabetes²³. The infants born to these mothers have embryopathology similar to those born to mothers known to have diabetes^{24, 25, 26}. Pedowitz also concludes that patients with an abnormal glucose tolerance curve during pregnancy should be treated as diabetics²⁷. Wilkerson found abnormal glucose tolerance tests in 3.4 per cent of 7,316 women screened in the Boston City and Boston Lying-In-Hospitals²⁸. One hundred and fourteen patients with abnormal curves were tested post partum and 10.5 per cent still had abnormal curves²⁹. Large babies were noted three times as frequently in those patients with abnormal curves who were untreated as were seen in patients with normal curves or who had abnormal curves and insulin therapy. Welsh noted that approximately 50 per cent of a group of 128 pregnant patients had abnormal oral glucose tolerance tests and that large babies and fetal loss was more common in those patients with abnormal curves. Glycosuria did not appear to be correlated with the abnormal glucose tolerance tests in his studies. He performed intravenous glucose tolerance tests on 27 of the 62 patients who had abnormal oral tolerance tests. Eight of these patients had abnormal intravenous tolerance tests. There were three perinatal deaths and two overweight infants in these eight women. Welsh's finding of essentially 50 per cent abnormal curves in pregnancy suggests that standard criteria for in-

terpretation are too liberal. Certainly the frequency of lag type curves due to slow absorption which is frequently seen in pregnancy makes the one hour or two hour post prandial value unreliable for diagnosing diabetes. Use of the intravenous tolerance test for diagnostic purposes appears desirable and more reliable during pregnancy.

Hormonal Aspects of Pregnancy In Diabetes

Smith and Smith (1933) found that a number of women suffering from pre-eclampsia had abnormally high levels of chorionic gonadotrophin in both the blood and urine³⁰. They later observed that these toxemic women also excreted estrogens and pregnanediol in unusually small amounts³¹. These authors then evolved a theory which attempts to explain the mechanism of the production of toxemia, the main principle of which states that the disease results from the release of a toxin from the placenta when its integrity is impaired by an interference with its blood supply³². Many of the Smith's early patients were diabetics who had been selected because of their unusual predisposition to eclampsia. Furthermore, as White has suggested, the degeneration of the pelvic vessels in long standing diabetes mellitus should predispose the diabetic to interference of the placenta's blood supply³³. The work of the Smith's formed the basis for White's advocacy of estrogen and progesterone replacement in the pregnant diabetic. The insulin requirement usually increases during pregnancy which may in part be due to increased adreno-cortical activity^{34, 35}. Gemzell³⁶ and Robinson³⁷ found that the 17 hydroxycorticosteroids in the blood increased progressively during the course of pregnancy. Gray's studies in diabetic pregnancies revealed no significant differences from the non-diabetics³⁸. White and Hunt suggested that the abnormal hormone patterns seen in diabetic pregnancies could be rectified by the regular administration of stilbesterol and progesterone¹¹. They noted a fetal mortality rate of 40 per cent in diabetic with abnormal hormonal balance. A later study by these authors revealed only a 10 per cent fetal mortality in a series of patients whose hormonal imbalance was corrected by appropriate hormone administration³⁹. A cooperative British report compiled by Dr. D. D. Reid in which a double blind control study using oral estrogens and progesterone in diabetic pregnancy failed to reveal any significant effect of the hormone therapy⁴⁰.

The fall of urinary pregnanediol levels in the last trimester of the unsuccessful pregnancies noted by Smith & Smith³² was also noted in the British study. Failure of the British workers to use the hormones parenterally make it difficult to compare their re-

DIABETES AND PREGNANCY / Boshell

sults with those of White³⁹. Stillbirths and neonatal deaths were noted in approximately 35 per cent of the diabetic pregnancies of the British series in both the treated and untreated groups compared to the 10 per cent incidence of White's treated group³⁹. It is regrettable that no one has run a strictly comparable double blind study to settle the status of hormonal therapy in diabetic pregnancies.

Infection During Pregnancy with Special Reference to the Urinary Tract

The studies of Kass⁴¹ and of Boshell, MacLaren and Metcalfe⁴² indicate that six to seven per cent of pregnant women develop significant bacteriuria (i.e., more than 100,000 organisms/ml. of urine). Forty per cent of the patients with bacteriuria later develop pyelonephritis⁴¹. Furthermore, Kass' studies revealed a 24 per cent incidence of prematurity and a 17 per cent incidence of perinatal death in the untreated bacteriuric mothers compared to only a 10 per cent incidence of prematurity and no perinatal deaths in the abacteriuric or successfully treated bacteriuric patients.

Many workers have demonstrated an increased incidence of urinary tract infection in patients with diabetes mellitus^{43, 44, 45}. Thus in the pregnant diabetic we have two conditions both of which are associated with a high incidence of urinary tract infection. Although definite data as to the incidence of urinary tract infection in the pregnant diabetic is unavailable, one would surmise that it should be rather high. It is of interest to note that specific therapy of the bacteriuria markedly decreased the incidence of the aforementioned associated complications. One might well postulate that the increased medical care and supervision of pregnant diabetics in some of the clinics with a high success rate may have included adequate therapy of bacteriuria which may have affected the outcome of the pregnancy to a greater degree than more esoteric measures such as hormone therapy.

The factors in pregnancy which predispose to urinary tract infection remain ill defined although multiple theories have been advanced. The anatomical changes secondary to the pelvic tumor of pregnancy⁴⁷, the smooth muscle atony which occurs after the third month of pregnancy, resulting in ureteral dilation along with the diminished ureteral peristaltic wave⁴⁷ and vesicoureteral reflux⁴⁸ have all been advanced as possible contributing factors. Bacteriuria has generally been considered to occur more frequently in the latter half of pregnancy at which time the conditions listed above are present⁴⁹. Kass has recently reported that the incidence of bacteriuria in pregnancy is about the same in the first

two months of gestation as in the seventh month, thus occurring prior to the onset of the anatomical changes discussed⁴⁴. Perhaps the hormonal changes which consist of increased production of chorionic gonadotrophin and corticosteroids in the early weeks of pregnancy contributes to the development of bacteriuria⁵⁰. Glycosuria which is a relatively common finding in pregnancy may be a contributing factor, however, glycosuria as produced by phloridzin does not increase the susceptibility of the female rat to intravesically administered bacteria⁵⁴.

Only time and careful investigation will reveal the true significance and relationship of infection to the outcome of pregnancy in the diabetic patient.

Management

The major objectives that one should have when treating a pregnant diabetic are as follows:

A. Maternal survival

B. Prevention of appearance or acceleration of existing complications.

C. Fetal Survival.

The objectives may be best obtained by physiological control of the diabetes during pregnancy. Diet is of major importance in this regard. The diet should be calculated for the individual patient on the basis of 30 calories per kilogram of ideal weight plus an additional 150 to 200 calories to allow the patient to gain no more than 14-16 pounds during the pregnancy. Approximately 40 per cent of the calories should be carbohydrate, 20 per cent protein and 40 per cent fat. An extra 50 grams of carbohydrate may be added during the last trimester.

Insulin dosage usually increases during pregnancy and should be changed as needed in an attempt to attain normoglycemia before meals and a daily output of glucose in the urine of less than 10 per cent of the total carbohydrate intake. By the same token one prefers to abstain from producing hypoglycemia. The above goals are frequently best achieved by splitting the dose of long acting insulin into a morning and evening dose usually giving about two thirds of the total dose in the morning and one third before the evening meal or bedtime feeding. Occasionally the morning dose may require supplementation with a short acting insulin.

Pregnant diabetic patients should have clean voided urine cultures when first seen and perhaps again in each trimester. Specific therapy should be administered if significant bacteriuria is discovered. Previous studies suggest that the antibiotics should be continued throughout the remainder of the pregnancy⁴¹.

Hydramnios is a very frequent complication of the diabetic pregnancy and every attempt should be made to keep it at a minimum. White recommends the use

of a one gram sodium diet, four grams of ammonium chloride per day, plus the use of diamox and mercurials as needed⁵⁰. If these measures fail, she suggests the use of trans-abdominal amniotomy which should not be performed earlier than two weeks prior to the expected date of good viability.

The employment of hormones is controversial. White has presented data suggesting marked benefit from the use of parenteral estrogen and progesterone from the time that she first sees the patient⁵¹. The reports of the British Medical Research Council's cooperative controlled trial of oral hormone replacement⁴⁰, and comparable results from Long et al⁵², Pedersen and Brandstrup⁵³, Stephens⁵⁴ and Black and Miller⁵⁵ without utilizing hormones suggest that excellent diabetic care may be much more important than hormonal replacement. Failure of the British workers to use parenteral hormones and their failure to give adequate doses to correct the measured hormonal imbalance prevent exact comparison with the excellent but uncontrolled studies of White.

The maternal mortality of pregnant diabetics has fallen to a low of less than 0.6 per cent in 3200 pregnancies according to Black and Miller⁵⁶. Thus it would appear that under present conditions in most clinics pregnancy is a safe venture for the diabetic. Furthermore, although the insulin requirement usually increases during pregnancy there is little evidence to indicate that the eye, renal and vascular lesions are accentuated provided the disease is well controlled during pregnancy⁵⁶.

After the 37th week of gestation there is a greatly increased risk of intrauterine fetal death however, the risk of neonatal death due to prematurity is high before the 36th week⁵⁷. Thus the 36th to 37th week appears to be the optimum time for delivery of most diabetics. The method of delivery should be individualized. The infant should be treated as a premature in all instances and by a physician experienced in the handling of these babies.

Summary and Conclusions

1. Diabetes is frequently difficult to diagnose during pregnancy, however, patients with an altered carbohydrate tolerance test appear to have an increased incidence of the same complications seen in the overt diabetic patient and dietary therapy at least, and possibly insulin therapy is indicated. This is more evident if the patient also has an abnormal intravenous glucose tolerance test.

2. Pregnant diabetic patients frequently show evidence of hormonal imbalance characterized by low urinary estrogen and pregnanediol levels and a high serum of urinary gonadotrophin. This imbalance is especially evident in the unsuccessful diabetic

pregnancies. The elevated levels of adrenocortical hormones in the blood and urine of pregnant diabetic patients appears to be no different than that seen in the pregnant non-diabetic.

3. The most important aspect of managing the pregnant diabetic patient is prescription of adequate diet and insulin plus other general medical measures including the use of diuretics as needed.

4. Evidence has been presented to suggest that bacteriuria and resultant pyelonephritis may be important causes of fetal wastage in diabetics.

5. The use of hormones in pregnant diabetics is a controversial and ill defined matter. The studies of White are impressive and warrant further investigation.

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MEDICAL FAIR WORTHY SUCCESS

The medical and health fair is over but the impact it left on Hall Countians will long be remembered.

People of all ages flocked by the hundreds to the Civic Building during both days of the fair to gape, gasp, listen and learn. It was as enjoyable as a three ring circus and as dramatic as a good adventure story. Above all it was an education, in lay terms, in medicine, health and science.

The 30 exhibits featured at the fair depicted the major areas of medicine confronted by doctors daily. A doctor was stationed at each booth to answer the eager and searching questions asked him. Many people stood patiently in long lines to have their lung capacity tested, arms pricked for TB skin tests, blood typed, chests x-rayed and to listen in wide eyed fascination to the beat of their hearts.

They stood spellbound to watch calm doctors and nurses perform their duties in two different type simulated but intent and concentrated operations.

Normally rambunctious youngsters, healthy specimens in their soiled football togs clustered around an iron lung and for the moment were quieted by the thought—"What if I was in there." Others stood and watched a space flight exhibit and dreamed of their future in this scientific age which seems to know no bounds.

Young girls and expectant mothers gazed at diagrams depicting the miracle of birth.

One enthusiastic doctor looked at a lady reading every word in an eye and sight display and proudly remarked, "Look at her reading that sign — she's really interested."

Sponsored and promoted by the Hall County Medical Society, the fair was the result of months of hard work

and the "culmination of random thoughts" by doctors begun several years ago.

The Society, the volunteer workers and the health associations which made it possible should be congratulated for bringing to Hall County a better knowledge of their work and an increased understanding of the medical and scientific professions.

The Daily Times
Gainesville, Georgia



SOME ASPECTS OF STRESS INCONTINENCE

Jack Lapidès, M.D., *Ann Arbor, Michigan*

Most cases of stress incontinence in the female are the result of a shortening of the urinary sphincter in the erect position

THERE ARE MANY TYPES of urinary incontinence in the female but probably the most common and most inconvenient one is that due to stress. Not only has stress incontinence been troublesome to the patient but has presented a problem in diagnosis and treatment to the physician. A primary reason for the difficulties associated with urinary incontinence has been the lack of a clear concept of the normal physiology of the bladder and urinary sphincter.

Although extensive research has been performed on micturition for many years,¹ a clear concept did not emerge until the present. Four important milestones in the evolution of the modern concept include the discoveries that (a) bladder smooth muscle possesses inherent tonicity^{2,3} (b) bladder smooth muscle is under cortical control⁴ (c) bladder smooth muscle is activated solely through the parasympathetic nerves⁵ and (d) the urinary sphincter is a tubular structure synonymous with the proximal 3.0 cm. of the female urethra or with the prostatic and membranous portions of the male urethra.^{6,7}

Urination in the Normal Subject

Micturition is actually a simple process governed by the higher centers in the normal individual. The bladder consists not only of a globular portion called the fundus but also of a tubular part, the urethra. The muscular layer of the urethra is a continuation of the muscle in the wall of the bladder^{5,6} and is innervated by the same parasympathetic fibers. The smooth muscle of the bladder possesses the qualities of tonicity and accommodation which are inherent in the smooth muscle, and independent of motor impulses from the central nervous system. The fundus

or globular portion of the bladder receives urine continually from the ureters and stores it at relatively low pressures until capacity is reached. The urine is prevented from flowing out of the bladder during the period of storage by the urinary sphincter. The urinary sphincter has been found to be a tubular structure synonymous with the proximal three-fourths of the female urethra or the prostatic and membranous portions of the male urethra; in both male and female these segments of urethra are actually the true bladder necks.^{5,7} The wall of the urethra contains much elastic tissue in addition to smooth muscle.⁶ The urinary sphincter maintains continence by virtue of the resistance its apposing walls present to fluid pressure. The elastic and muscle fibers in the urethral wall keep the lumen of the urethra narrow without the aid of motor impulses from the central nervous system.

When intravesical pressure is markedly elevated by exertion, urethral resistance must be increased to prevent urinary incontinence. In the normal male and female human this is accomplished by the two-fold action of the striated muscle of the urogenital diaphragm and pelvic floor.⁷ These muscles compress the urethra or urinary sphincter circumferentially as well as elongate it by pulling it cephalad toward the fundus. The net result of the striped activity is to decrease the caliber of the urethral lumen, to increase the tension of the urethral walls against its lumen and to increase the length of the urethra—all factors which increase the resistance of the urinary sphincter to the flow of fluid through it. The levator ani and muscle of the urogenital diaphragm can be contracted or relaxed voluntarily. They can contract reflexly also as in standing, coughing, sneezing, etc. These muscles are essential for the abrupt termination of urination.^{3,9}

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Mechanics of the Normal Urinary Sphincter

Studies in normal women⁷ reveal that the urinary sphincter or urethra is a mobile structure whose length varies with type of activity. A young nulliparous woman under spinal anesthesia may demonstrate a urethral length of 3.8 cm. If she is perfectly relaxed in the supine position, the urethral length will still be 3.8 cm. without anesthesia. Voluntary contraction of the levator ani muscles will lengthen the urethra to 4.3 cm. Reflex contraction of the levator ani, as in changing from the supine to the erect position, will also increase urethral length to 4.3 cm. The urethral length of 35 normal women without urinary incontinence varied from 3.0-4.5 cm. with an average of 3.8 cm. in the supine and standing positions.

It is interesting to note that intra-urethral resistance to retrograde flow of fluid⁷ is increased everytime the urethra is lengthened; and the urethra is elongated when the levator ani and external urethral sphincter are stimulated to contract as in coughing, straining, sneezing and sudden voluntary interruption of urination.

Intravesical pressure in the normal individual varies also with type of activity. In the supine position the average intravesical pressure in the female is approximately 17 cm. water. On standing the pressure is increased to 32 cm. and on straining it is elevated to 60 cm. A portion of the intravesical pressure in the relaxed, supine position, and the increases beyond that pressure observed on standing, straining or coughing are due entirely to contraction of the striated muscle surrounding the body cavities.⁷

When normal females cough or strain, a "beak" or "infundibulum" of bladder fluid contents enters the proximal third of the urethra and then returns to the bladder after cessation of exertion.^{10,11} Apparently the urinary sphincter cannot keep the urine confined entirely to the fundus of the bladder when intravesical pressure is increased abruptly; urine is pushed into the lumen of a portion of the urinary sphincter.

The Lesion in Stress Incontinence

*The basic lesion common to female patients with stress incontinence was found to be an abnormally short urethra when the patient assumed the standing position.*¹² The urethral length in the supine position in these patients was frequently within normal limits but on assuming the standing position, there was a shortening or telescoping of the urethra to an average length of 2.3 cm. as contrasted with 3.8 cm. in the normal patient. It is evident that if the length of the urinary sphincter or urethra is decreased sufficiently, stress incontinence will result—particularly when it is known that stress forces urine

part way down the urethra in the normal female. A 3 cm. urethral length in the standing position seems to be the critical length at which transition from continence to incontinence occurs.

An abnormally short urethra is not invariably associated with stress incontinence and a normal length urethra in the standing position is not a guarantee against stress incontinence. Other factors such as intravesical pressure, status of the urethral epithelium and tonicity of the muscle and the elastic tissues in the wall of the urethra play a part in determining the effectiveness of the urinary sphincter in maintaining urinary continence.

On occasion the patient may have scar tissue replacing a portion of the normal muscular and elastic tissue of the urethral wall. Urethral length in these patients may be within normal limits in both the supine and standing positions, but the individual may still exhibit stress incontinence. Under these circumstances the actual length of the urethra or sphincter is normal but the functional length has been decreased by the dimensions of the segment of scar tissue; *adequate tension of the urethral wall requires normal muscle and elastic tissue around the entire circumference of the urethra.*

A decrease in the functional length of the urinary sphincter or urethra can be produced by a urethrovaginal fistula. Again, there is inadequate resistance by the urethral wall because of an opening in its circumference. In some patients the urethral length is decreased in addition to the functional shortening caused by scar tissue or fistulas.

In our experience fibrous tissue formation has been produced by electroresection of the urethra for various reasons, inadequate repair of urethrovaginal fistulas and iatrogenic trauma to the urethral floor during transvaginal operative procedures.

Intravesical pressure is an important factor in the apparently mysterious appearance and disappearance of stress incontinence under certain conditions. It has been shown¹² that patients with large cystoceles and hernias do not develop high intravesical pressures on exertion. This is apparently due to the fact that a high pressure requires a compression of the body cavity by all of the striated muscles surrounding the cavity. If there is a weak area in the muscular wall of the perineum or abdomen, the pressure will be dissipated by the bulging of the hernia or cystocele. Thus a patient who is a potential candidate for stress incontinence because her urethra shortens abnormally in the erect position may not show stress incontinence if she has a large cystocele. When the cystocele is repaired with resultant increase in intravesical pressures on exertion, incontinence makes its appearance. The reverse has been found to be true also in that some patients with stress incontinence have demonstrated marked improvement in urinary

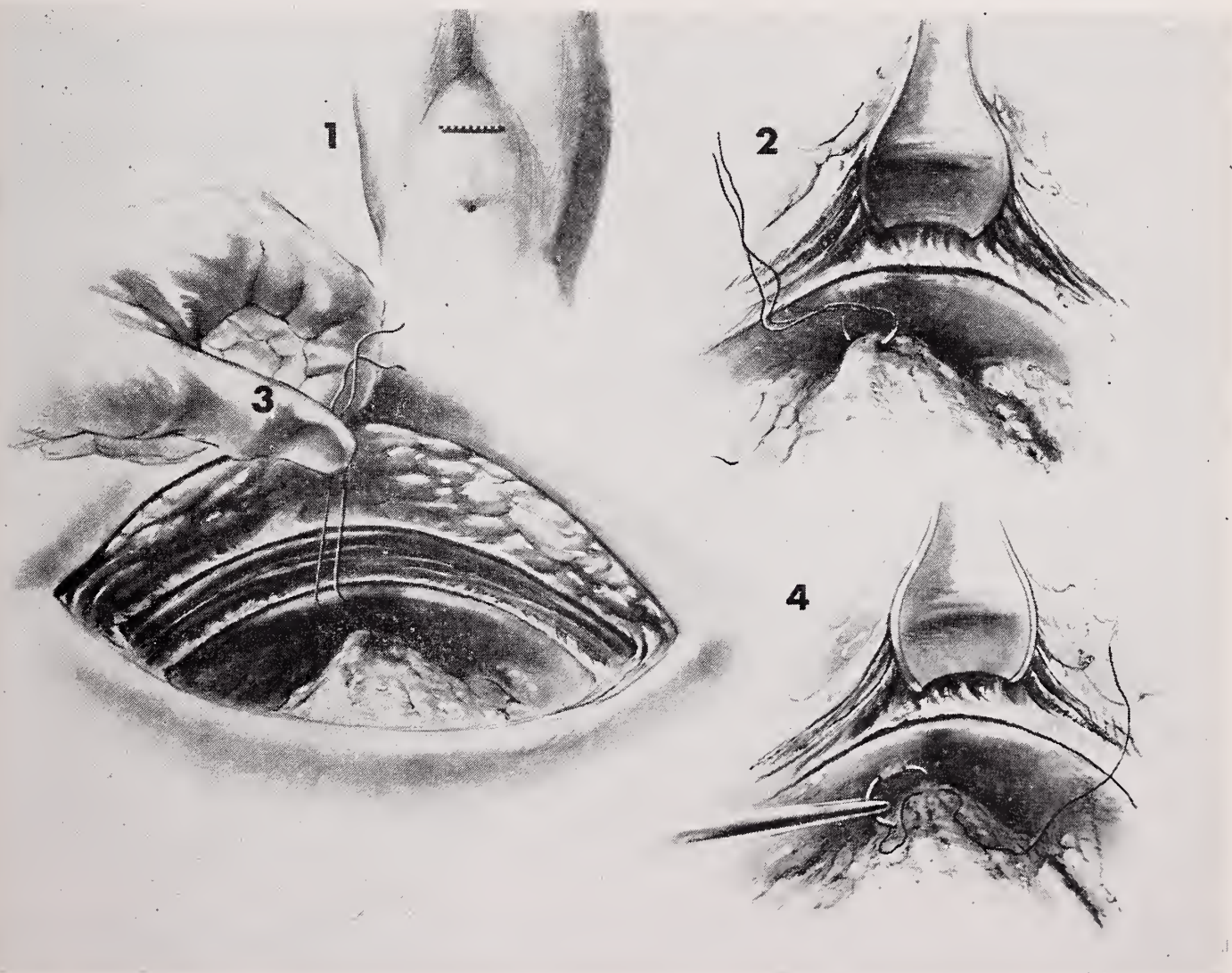
control with the development of a large cystocele¹³ or uterovaginal descensus.¹⁴

Therapy of Stress Incontinence

If most cases of stress incontinence in the female are the result of a shortening of the urinary sphincter in the erect posture, then logical therapy entails elongating and securely fastening the urethra so that collapse or telescoping does not take place when the patient stands. This endeavor has been accomplished

in a most simple and effective manner by utilizing a procedure designated as Anterior Urethropexy.¹²

The patient is given a spinal anesthetic and catheterized with a calibrated retention catheter. The bladder is drained of urine and the catheter left in place. The urethra is approached through a transverse incision made two fingersbreadth above the symphysis pubis (Fig. 1). After incising the skin, subcutaneous tissue and rectus fascia, the recti muscles are retracted laterally to expose the bladder.



The patient is placed in moderate Trendelenburg position in order to move the contents of the peritoneal cavity cephalad and away from the operative field. The periurethral fat is gently wiped from the anterior surface of the urethra so that the urethral wall can be readily identified. Two parallel rows of interrupted chromic catgut sutures are taken through the anterior wall of the urethra and the overlying symphysis pubis and rectus fascia in order to stretch the urethra and fix it to immobile symphysis and rectus fascia.

The technique involves the use of zero (1-0) chromic catgut suture material and a #6 Mayo round point needle. The surgeon mentally divides

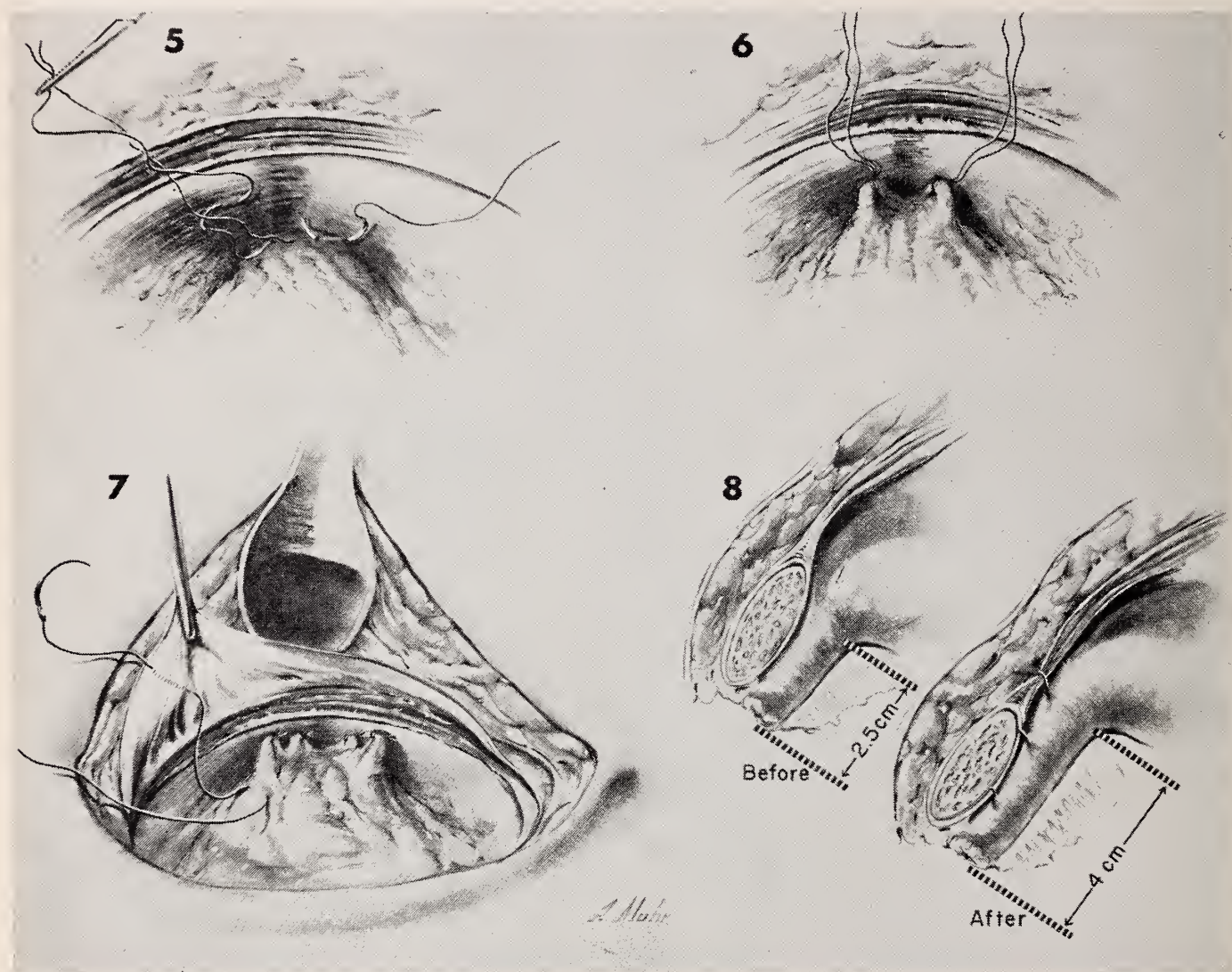
the anterior urethral surface into two longitudinal halves. The first suture is placed through the most distal portion of the left half of the anterior urethral wall as illustrated in Figure 2. The suture is taken in a transverse fashion through the entire urethral wall and incorporate about 1 cm. of tissue in the bite. Before continuing the suture through the periosteum of the symphysis, the suture is drawn taut and held close to the overlying symphysis in order to judge the place where the suture must be taken so that it will hold the urethra taut (Fig. 3). The needle is then placed into the periosteum of the desired area and gently pushed and pulled *in the arc of the needle* through the periosteum (Fig. 4). The ends of the

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suture are held while another suture is taken in a similar manner through the most distal portion of the right half of the anterior surface of the urethra (Fig. 5). Each suture is then tied (Fig. 6).

The next pair of sutures are placed about 1 cm.

proximal and in a manner similar to the first pair. The third pair of sutures are placed 1 cm. proximal to the second pair; these sutures are usually taken in the region of the vesical outlet and fastened to overlying rectus fascia (Fig. 7). Figure 8 illustrates a lateral view of the urethra before and after Anterior Urethropexy.



A Penrose rubber drain is left in the perivesical space and the abdominal wound closed in an appropriate fashion. The urethral catheter is removed in four days and the rubber drain is withdrawn within 24-48 hours after the catheter if there is no unusual drainage. One can check the effect of Anterior Urethropexy immediately after the operation by noting the urethral length. The urethral length in the standing position can be obtained just prior to removal of the catheter on the 4th postoperative day. A urethral length varying from 4-5 cm. in the standing position indicates that the operation has been performed properly.

As mentioned previously stress incontinence may occur in an individual with a urethra which is of normal length in measurement but which, on urethroscopy, reveals a defect in its wall such as a

scarred area or a fistulous stoma. The defective area serves to decrease the functional length of the urethra and predisposes to stress incontinence. Appropriate treatment for these individuals involves obliteration of the defect in the urethral wall and restoration of muscular continuity throughout the urinary sphincter or urethra. Since the posterior urethral wall is usually involved in urethrovaginal fistulas and other types of traumatic injury, a transvaginal approach is used to correct the stress incontinence.

Irrespective of the type of urethral defect the first step in the repair involves mobilization of the anterior vaginal wall well beyond the urethrovesical junction. If the defect is confined to the urethral wall as it may well be in iatrogenic injury during transurethral resection of the urethrovesical junction, then the anterior vaginal wall is mobilized and

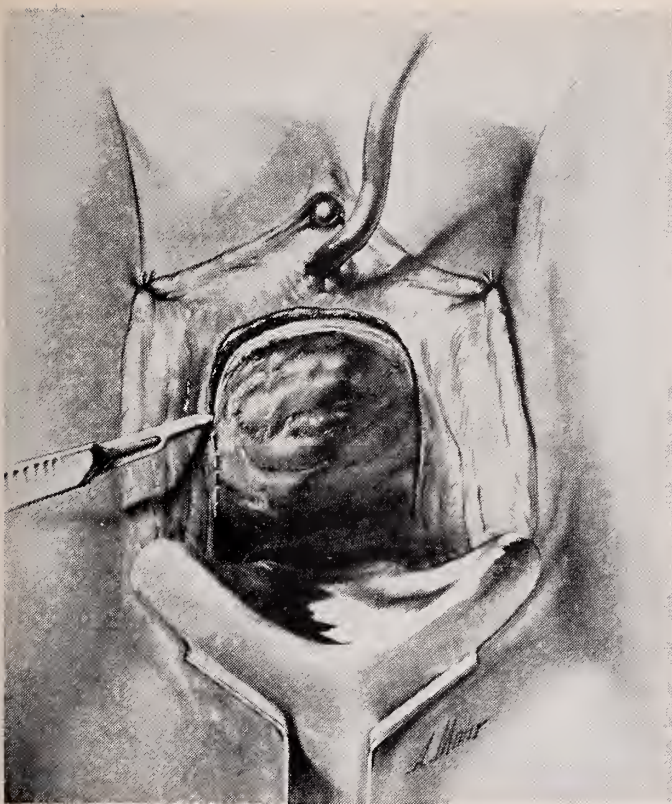


Figure 9



Figure 10

a flap formed (Fig. 9). The portion of urethra involved by scar is then excised (Fig. 10). One must make certain that all of the scar tissue is removed for any vestige remaining will prevent the urethral muscle and elastic tissue from exerting adequate tension throughout its entire circumference. The amount of urethral wall to be resected can be determined only by urethroscopy. If necessary, the entire floor of the urethra can be excised without trepidation. After excision of the desired tissue, the margins of normal urethra are approximated to each other in a longitudinal fashion by interrupted 00 or 000 chromic catgut sutures taken through the periurethral tissue. The urethral mucosa and most of the muscle wall are not penetrated by suture because of their delicacy and friability. The edges of the incision can be apposed quite readily by the use of stitches

taken through the tough periurethral tissue. The undersurface of the anterior vaginal flap is then approximated to its previous bed with interrupted, staggered 00 or 000 chromic catgut sutures (Fig. 11). This maneuver minimizes dead space and provides a solid vascular floor for healing of the urethra. The urine is diverted via an inlying urethral catheter for a period of three weeks.

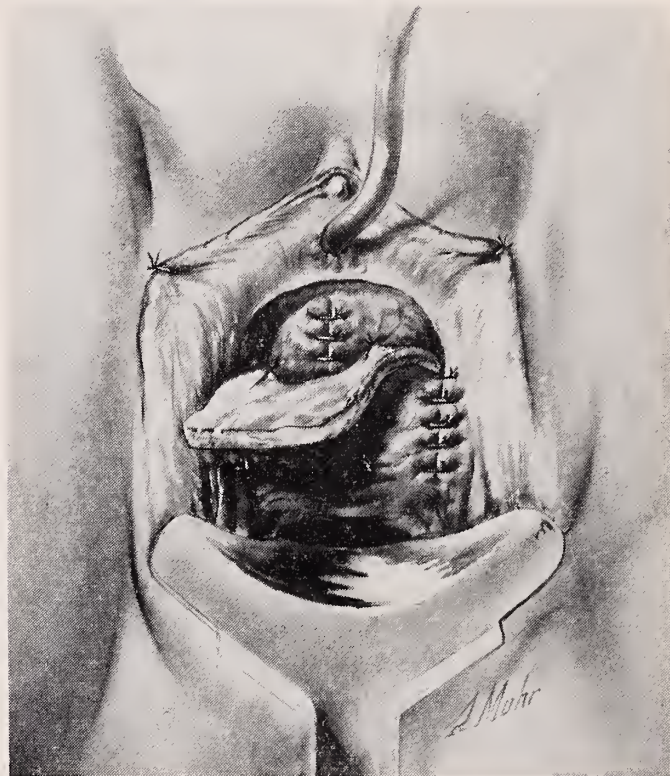


Figure 11

In patients with a short urethra and a urethral defect, a combined approach is used. First the urethra is exposed transvaginally, a vaginal flap formed and the urethral defect repaired. Before replacing the vaginal flap, the bladder and urethra are exposed suprapubically and an Anterior Urethropy performed. After closing the suprapubic wound, attention is redirected to the vagina where the vaginal flap is reanastomosed. The Anterior Urethropy is performed prior to the vaginal flap anastomosis in order to prevent fixation of the urethra before it is elongated and fixed from above.

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RE-EVALUATION AND APPLICATION OF INTERPOSED NON-METALLIC FILTERS IN DIAGNOSTIC RADIOLOGY

John J. Douglas, M.D., *LaGrange*

A simple clay filter is described as an adjunct in obtaining more critical detail and information with a minimum of radiation exposure to the patient.

THE EVER-INCREASING importance of an initial earlier diagnosis, especially of the neoplastic lesions of the chest, challenges each one of us to employ all of the resources and techniques at our command in an effort to obtain radiographs yielding the maximum visible detail and information at the time of the initial film study.

We are constantly changing and improving our x-ray diagnostic methods and techniques; or applying a "new twist" to established routines in attempting to achieve better results. The idea and applicability of a filter, any filter, is certainly not new. It has been or is being used daily. Filtered films are not going to replace the standard procedures, but its usage could serve as a valuable adjunct to our present day methods.

Various filters ranged from the opaque material attached to the cassette to the following: interposed paper between two films in a single cassette; brass, copper, aluminum and lead foils and wedges; iodine wedges; opaque fluids in different concentrations in plastic bags or balloons, and the like. These, however, are still fairly restrictive to certain locations and types of examinations. Then, too, there is the added radiation whenever additional films or sets are necessary.

The filter, as you know, holds back some of the rays from being absorbed by the film in its passage through the filter and the body, and allows an increased penetration and intensity of the higher K.V. used to reach the desired area due to its composition, thickness, and varying contour. The filter thereby balances the various densities of the different

anatomical structures or diseased states and tissues. This equalization is achieved, in part, by the higher K.V. now used—or by the supervoltage range. However, I believe that a special filter as herein described can accomplish a better and easier balance within the average range of equipment and technic.

The characteristics desired in a usable filter are as follows:

1. Simplicity (easily shaped or molded to desired thickness and contour).
2. Adaptability (easily molded for various areas of the body).
3. Availability (purchased at any art store, stationery store).
4. Reliability (a good grade of material does not deteriorate easily).
5. Low cost (\$.50 per pound—comes in different colors).
6. Efficiency (does not impart any significant artefact). Does not dry out.

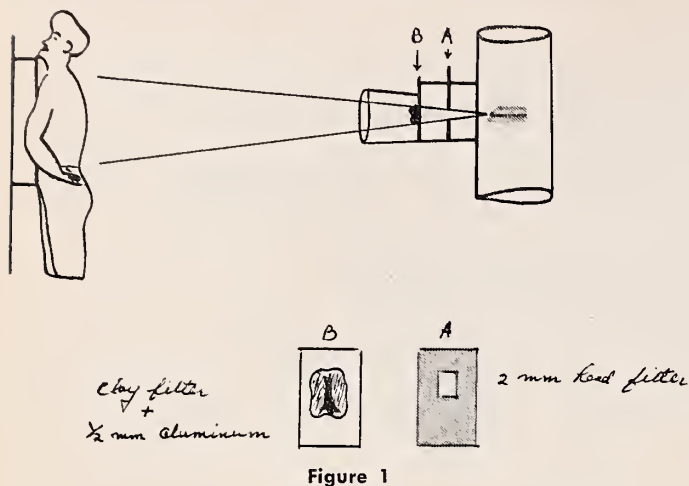
The modeling clay used in this presentation has the above mentioned characteristics. It should be the kind that artists or sculptors use. It does not dry out, or crumple. It retains its molded shape or contour. I have been using this type of filter since 1949 and have found it a very useful adjunct in obtaining more detailed information.

Method: (for chest films)

A two mm lead filter with a suitable sized hole is cut out and placed in the slot reserved for the carriage aluminum filters. This hole can be so placed that it serves as a collimator and directs and keeps the rays above the waist. (Figure 1)

The clay filter is anchored to a one-half mm of aluminum filter by scotch tape and inserted at the

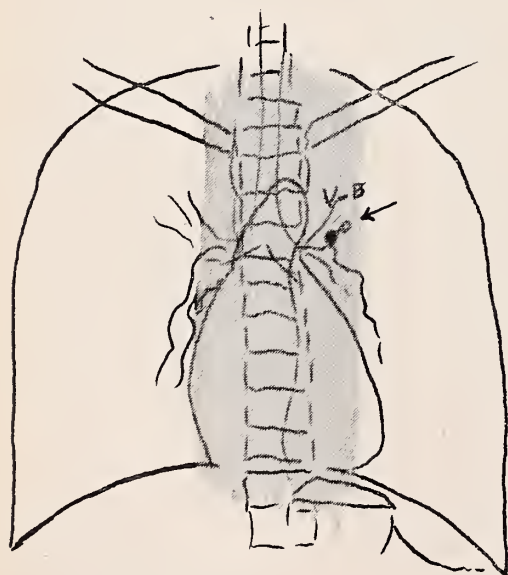
Presented at the 107th Annual Session of the Medical Association of Georgia, May 7, 1961, Atlanta, Georgia.



base of the cone—with the filter projecting into the inside of the cone—and inserted into its proper place. The exposure can then be made, with a higher K.V. to a desired density and detail and visibility of the part x-rayed. The two mm lead filter is removed for studies other than the chest.

Most of the earlier chest lesions occur in and about the central hilar or mediastinal zone. I call this area the “must see” zone. It contains the major structures, the predominant tumor area, the lymph nodes, the vascular structures and pattern of the hilar areas and the secondary bronchial radicles. The use of an added filter and a proper exposure improves the over-all visibility and detail of the entire chest.

Exposure for the mediastinum darkens the lung



Shaded area - Most important zone

* V-B ← end-on Vessel & Bronchus

Figure 2

areas. Conversely, lung techniques are inadequate for the mediastinum. An extra film, and exposure and radiation is necessitated. For years, our equipment did not permit us to use high K.V. penetration, and we could not take advantage of the increased latitude, and visibility.

The properly filtered and exposed film shows the following features: on a single film. (Figure 2)

Lung vascularity and parenchyma; heart size and configuration; the retrocardiac areas; the aorta as to size, course, and condition (sclerosis-plaques, etc.); the trachea, bronchi, paratracheal areas, subcarinal area; medial pleural reflections; paravertebral zones; thoracic spine; hilar area in better detail and visibility—particularly on the left side; subdiaphragmatic areas.

The effect of the filter is, of course, best seen when one side of the chest is quite dense, or mottled, and diseased. The ordinary technics blacken the opposite side whenever sufficient penetration is needed to obtain more information on the affected side. The application of the filter balances the two sides and more overall detail is obtained.

Incidental findings occasionally more readily demonstrated on a single filter film include the following: hiatus hernia—with or without a fluid level; achalasia; foreign bodies in the heart—such as bullets, needles, metallic fragments, and the like; spinal change such as a collapse, or sclerosis, or disease; paraspinal pathology; subdiaphragmatic pathology such as calcifications, masses; and the like.

I'd like to present a case which illustrates the value of a filtered film as well as the value of a much more careful and necessary scrutiny of the middle or “must see” zone.

Chest study case of Mr. W—a white male—of 65 yrs. of age: Chief complaint of “progressive weakness, and dyspnea, and weight loss.” Positive findings: An elevated sed rate. Slight anemia. Emphysema. Thin elderly male with obvious weight loss. Chest film: Emphysema. Question of Bronchiectasis. Old healed acid-fast scars. Question of a left hilar mass. Notice of an increase in the visualized left hilar vessel-bronchus relationship. (Figure 2)

Subsequent films showed a pneumonitis, and secondary infections in the left hilum and into the left upper lobe. These changes became more evident in spite of any type of therapy. The architecture of the left hilum changed, as did the visibility of the previously noted vessel and branchus relationship. Cytology, bronchoscopy, smears, and other studies were negative. Autopsy revealed a neoplasm of the left hilum and secondary radicles of the bronchi.

A review of some other cases of neoplasm of the lung showed the same type of change in the architecture prior to the appearance of masses or nodes; and

in the vessel-bronchus relationship whenever it was visible.

To be sure, the following tabulation is a very small one, and in a larger number of cases may prove not to be significant or reliable. But, in this review it proved to be an interesting observation and finding.

Carcinoma of the lung:

Age:	sex;	vessel diameter	inter-distance	Bronchus diameter
67	— male —	2 mms	— 7 mms —	4 mms
65	— male —	4 mms	— 7 mms —	4 mms
58	— male —	5 mms	— 7 mms —	4 mms
65	— male —	2 mms	— 6 mms —	7 mms
68	— male —	4 mms	— 7 mms —	2 mms on 3-9-56 film
		3 mms	— *10 mms —	3 mms on 11-1-56 film
54	— male —	6 mms	— 4 mms —	4 mms. on 9-2-59 film
		6 mms	— * 1 mms —	4 mms on 10-3-59 film

(Although the distance was less on the 2nd film — the relationship position changed — and the general architecture of the area was altered and became hazy.)

Hodgkin's:

19	— female —	2 mms	— 6 mms —	3 mms in 1950
		3 mms	— * 6 mms —	4 mms in 1953

(Enlarged central masses and nodes and architectural pattern remained essentially the same after various methods and treatments had been given — during the 3 years — compatible with an arrested progress; or refractory process; or dormant process.)

Leukemia:

Age 34 years—Vessel 6 mms—interdistance two mms—Bronchus four mms, seven cases of metastasis to the lungs, of course, did not have any change in the hilar areas; or affect the hilar vessel-bronchus relationship. Recognizable end-on vessel and bronchus relationship in non-malignant cases showed no vessel over five-six mms; no intervening distance over five mms; and no bronchus over five mms. It was seen, in the present review—in 65 per cent of the normal films of several hundred chest films.

Therefore, one might assume that as the tumor progresses, even before the mass or node is noticed, that it surrounds, or infiltrates, or spreads and distorts the hilar architecture; appearance and density is changed early. It begins to occlude the bronchial branches and radicles. The secondary and tertiary radicles of the bronchi are certainly not as rigid and resistant to extrinsic and intrinsic pressures and invasions as are the main bronchi at the bifurcation. Therefore, these areas are going to change their pattern before other more advanced effects are going to be recognized; unless the process is confined to the curve of the main bronchus. Eventually, the signs that we see of infection, atelectasis, emphysema, and nodes or masses manifest themselves. By then, it is not an early sign, or evidence.

Therefore, I believe, that the earliest sign or evidence of a possible lesion, whether benign or malignant, is in the architectural pattern change;—in the

vessel—interdistance—bronchus relationship whenever visible; and in the clarity of the hilar interstices.

The central “must see” mediastinal zone must therefore be diligently scrutinized on every chest film for any possible change in the general structure, pattern, and densities, and broncho-vascular relationships. A “filtered” chest film will serve as an adjunct in enabling one to obtain more detailed information of the overall type and degree, of various portions of the all-inclusive chest film. A base line chest film on every patient, for comparison and follow-up, should be mandatory and available to all who undertake to take care of the patient.

The plastic filters can also be used for any part of the body wherein a balance of densities; or better detailed visibility is needed. This is particularly important in laminogram work wherein usually one set of films are exposed for the mediastinum, and one set for the parenchyma. With a filter, only one set need be taken—to show both areas with more detailed visibility and balance. It can also be used to advantage in patients who are very thin, or emaciated; in placentograms; pyelograms for the mid-quadrant lighter density visibility; cervico-thoracic lateral spines; shoulders—knees; lateral face and skull views; and the like. (Figure 3)

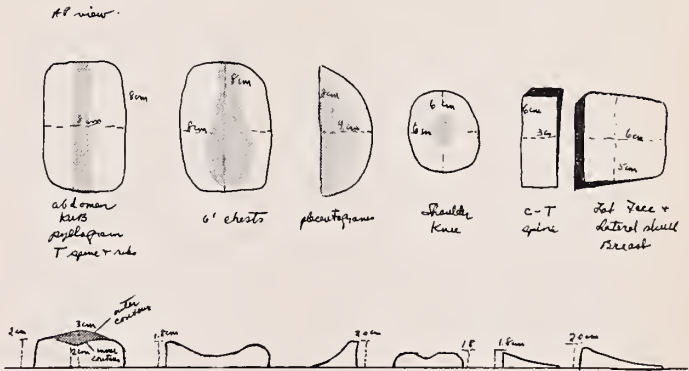


Figure 3

Summary

A very flexible modeling clay interposed filter is presented which permits better penetration and balance and visibility of the over-all normal structures and processes, as well as pathological processes on a single film. This type of filter provides a useful adjunct in obtaining more critical detail and information with a minimum of radiation to the patient; as well as obtaining diagnostic films within the range of the average x-ray office or departmental equipment.

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SOME CUTANEOUS ASPECTS OF INTERNAL DISEASE

Sidney Olansky, M.D., *Atlanta*

The skin findings in four of the "collagen" diseases are reviewed.

MANY SYSTEMIC DISEASES have cutaneous aspects, but the group which has received the most attention has been the so-called collagen disease group. In view of the limited time I shall not attempt to go beyond the collagenoses. Perhaps the most important of these in terms of numbers of patients is lupus erythematosus.

Discoid Lupus Erythematosus

There is a form of lupus erythematosus which is confined to the skin and which is referred to as chronic discoid lupus erythematosus. This is a distinctive scaling eruption of the skin ordinarily distributed to the face, scalp, ears, chest and arms, and which has a very prolonged chronic course, ultimately productive of atrophy, scarring and hyper or hypopigmentation. This is not accompanied by related symptoms, signs or laboratory evidence of systemic disease. It affects both men and women in adult life and rarely has its onset in childhood or old age. Its relation to systemic lupus erythematosus is unsettled, but there is much to suggest that it is a different disease and that the so-called transition forms are systemic lupus from the onset. The disease may vary from a single lesion persisting for a long time or may become very extensive at times, involving the face, scalp, arms, back and chest. The mucous membranes, particularly the lips or the buccal surface of the cheek, may be involved although not too commonly.

The typical lesion of discoid lupus erythematosus is a sharply margined plaque with a gray adherent scale and follicular plugging. Often in a new lesion, if the scale is removed, the follicular plugs come with it producing the so called carpet tack scale. Atrophy, telangiectasia and pigmentary changes soon are evident. The lesions are symptomless as a rule, but the patients frequently complain of irritation when they are exposed to sunshine. The biopsy reveals a characteristic pathologic picture. By definition discoid lupus erythematosus infers no systemic involvement, therefore it is essential that a blood

count, urinalysis, sedimentation rate and blood proteins be performed when the diagnosis is made. Also, there should be no history of symptoms or signs suggesting involvement of serous membranes, vascular lesions, etc. It must be differentiated from the following:

1. Seborrheic dermatitis. This eruption occurs in similar areas to discoid lupus erythematosus but usually occurs in patients with very oily skin. The scales are greasy and the lesions have less tendency to be indurated. In addition when treated they leave no scar or atrophy.
2. Polymorphous light eruptions. This is a condition where patients are sensitive to light, usually at certain times of the year such as early spring or mid-summer, and lesions are produced which may be clinically and pathologically indistinguishable from discoid lupus erythematosus. However, the lesions appear only in areas which have been exposed to light, not in protected regions such as the scalp. They follow a much more labile course and do not tend to persist long if exposure to the sunlight is prevented.
3. Rosacea. This may occur in the butterfly distribution but is the result of vaso-dilatation and is often associated with pustules.
4. Solar erythema in light skinned individuals may resemble lupus erythematosus.
5. Contact dermatitis may on occasion resemble lupus erythematosus.

Treatment of discoid lupus erythematosus now is almost confined to the use of antimalarial drugs.

Subacute Lupus Erythematosus

This is essentially a clinical diagnosis. These patients have some signs of systemic lupus erythematosus and cutaneous lesions which are more extensive and more acute than those of discoid lupus erythematosus, and yet there is not sufficient clinical or laboratory evidence to support a diagnosis of systemic lupus erythematosus.

Presented at the 107th Annual Session of the Medical Association of Georgia, May 9, 1961, Atlanta, Georgia.

Acute Disseminated Lupus Erythematosus

This is a serious disease. There may be no cutaneous lesions associated with acute disseminated lupus erythematosus, but when they do occur as is true in about 50 per cent of the patients, they often furnish a valuable index to exacerbation and remission of the disease and may be very helpful in suspecting the diagnosis initially. The cutaneous lesions of systemic lupus erythematosus involve the face most commonly, they tend to be symmetrical and frequently take the butterfly or batwing outline on the face. This may be a mere erythematous or suffused area, but with more severe involvement the erythema increases and it becomes more marked. It may even approach the appearance of a cellulitis and at times even show exudation and crusting. All exposed areas may become involved, hair loss is common but is usually reversible unlike that associated with discoid lupus erythematosus. When the cutaneous lesions subside, pigmentation is the rule and atrophy is uncommon, unlike discoid lupus erythematosus. Other cutaneous manifestations may be telangiectatic vessels on the fingertips, splinter-type purpura under the nails, erythema and scaling and telangiectasia over the knees and elbows and palmar erythema, particularly over the fingertips. The diagnosis of systemic lupus erythematosus is well known to all of you, and I shall not go into detail about this.

Scleroderma

Scleroderma is a collagen disease which also has localized and systemic forms. Localized scleroderma also known as morphea, consists of circumscribed plaques of hardened atrophic skin. They may occur at any site and may present as linear bands, oval plaques or multiple plaques. In the early stages a violaceous border may be present, and the lesion may be edematous. It is generally a benign process and there are few recorded instances of this disease becoming systemic. Systemic scleroderma, however, is a grave, chronic, systemic disease in which large tracts of connective tissue throughout the body are involved. The skin is the most obvious clinical site, but any organ may be involved. The disease most commonly affects women between the ages of 30 and 50, but no age or sex is exempt. The skin changes may be preceded by vascular findings such as Raynauds's phenomenon and may be confined to the face and hands. This is considered by some to be a separate entity called acrosclerosis and by others merely a less extensive form of systemic scleroderma. In early cases the diagnosis is suspected by feeling the tightness and induration of the skin, later the patient becomes hide bound and the diagnosis is generally obvious. Calcification of the affected areas commonly occurs as do ulcerations, particularly over

the fingers and other traumatized areas. Treatment is generally unsatisfactory, although there have been many claims for many drugs.

Dermatomyositis

Dermatomyositis is a rare syndrome in which the predominant findings are inflammatory changes in the skin and in the muscles. It has been associated with neoplasms in various sites, but usually when this occurs the neoplasm precedes the dermatomyositis. It may affect either sex over a wide age range, and this condition often affects children. Like lupus erythematosus this disease may have no cutaneous manifestations, but when they do occur they may be very helpful in arriving at a diagnosis. The most pathognomonic lesions are those occurring on the face as an erythema involving the eyelids associated with telangiectasia producing a heliotrope color. The eyelids are usually swollen, and the same eruption may extend down the sides of the nose over the cheeks. The cutaneous lesions may be very suggestive of disseminate lupus erythematosus. As the disease progresses, the skin may show poikiloderma, that is telangiectasia, atrophy and pigmentation, similar to the appearance seen following x-ray therapy. In some instances there may be a scleroderma-like picture associated with muscle weakness, and in advanced cases calcification may appear as it does following scleroderma.

The differential diagnosis includes a wide range of conditions namely, photosensitivity reactions, lupus erythematosus, scleroderma, erysipelas, and trichinosis. A skin biopsy is not diagnostic. Muscle biopsy merely shows myositis. The differentiation from trichinosis is the most difficult, since both diseases may produce swollen eyelids, muscular weakness and eosinophilia. Therapy is dependent on ACTH or the corticosteroids which usually bring about a marked beneficial effect.

Periarthritis Nodosa

This is a systemic disease involving vessels in a wide area of the body. Males are affected four times as often as females, and the kidney is attacked in about 80 per cent of the cases. Subcutaneous nodules may occur in some 25 per cent of the cases, petechia in 15 per cent and the disease may be associated with many of the toxic eruptions such as erythema nodosum, erythema multiforme, urticaria etc. The following are a few examples of this condition. Treatment consists of ACTH and steroids, although it is often unsatisfactory.

Summary

The cutaneous manifestations of lupus erythematosus, scleroderma, dermatomyositis and periarthritis nodosa have been reviewed.

blood pressure approaches normal
more readily, more safely....simply
with
Salutensin[®]
(hydroflumethiazide, reserpine, protoveratrine A—antihypertensive formulation)

Early, efficient reduction of blood pressure. Only Salutensin combines the advantages of protoveratrine A ("the most physiologic, hemodynamic reversal of hypertension"¹) with the basic benefits of thiazide-rauwolfia therapy. The potentiating/additive effects of these agents²⁻⁸ provide increased antihypertensive control at dosage levels which reduce the incidence and severity of unwanted effects.

Salutensin combines Saluron[®] (hydroflumethiazide), a more effective 'dry weight' diuretic which produces up to 60% greater excretion of sodium than does chlorothiazide⁹; reserpine, to block excessive pressor responses and relieve anxiety; and protoveratrine A, which relieves arteriolar constriction and reduces peripheral resistance through its action on the blood pressure reflex receptors in the carotid sinus.

Added advantages for long-term or difficult patients. Salutensin will reduce blood pressure (both systolic and diastolic) to normal or near-normal levels, and maintain it there, in the great majority of cases. Patients on thiazide/rauwolfia therapy often experience further improvement when transferred to Salutensin. Further, therapy with Salutensin is both economical and convenient.

Each Salutensin tablet contains: 50 mg. Saluron[®] (hydroflumethiazide), 0.125 mg. reserpine, and 0.2 mg. protoveratrine A. See Official Package Circular for complete information on dosage, side effects and precautions.

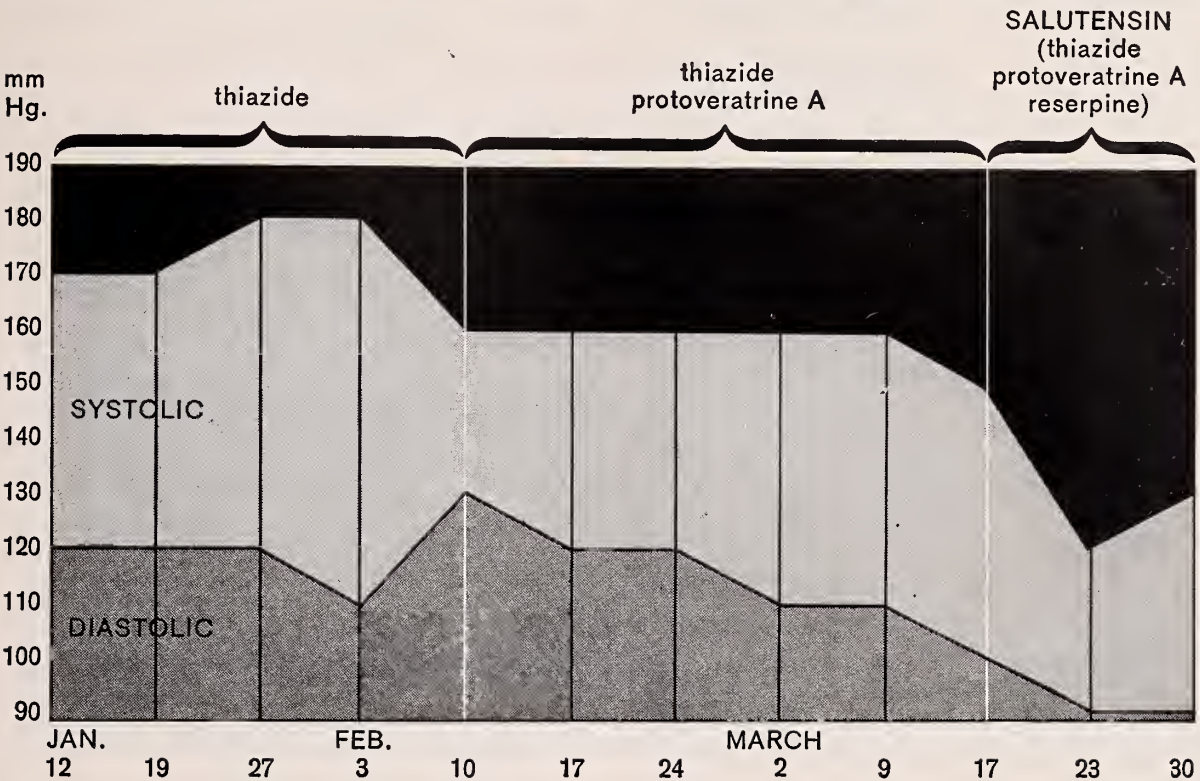
Supplied: Bottles of 60 scored tablets.

References: 1. Fries, E. D.: In Hypertension, ed. by J. H. Moyer, Saunders, Phila., 1959 p. 123. 2. Fries, E. D.: South M. J. **51**:1281 (Oct.) 1958. 3. Finnerty, F. A. and Buchholz, J. H.: GP **17**:95 (Feb.) 1958. 4. Gill, R. J., et al.: Am. Pract. & Digest Treat. **11**:1007 (Dec.) 1960. 5. Brest, A. N. and Moyer, J. H.: J. South Carolina M. A. **56**:171 (May) 1960. 6. Wilkins R. W.: Postgrad. Med. **26**:59 (July) 1959. 7. Gifford, R. W., Jr.: Read at the Hahnemann Symp. on Hypertension, Phila. Dec. 8 to 13, 1958. 8. Fries, E. D., et al.: J. A. M. A. **166**:137 (Jan. 11) 1958. 9. Ford, R. V. and Nickell, J.: Ant. Med. & Clin. Ther. **6**:461, 1959.

all the antihypertensive benefits of thiazide-rauwolfia therapy plus the specific, physiologic vasodilation of protoveratrine A

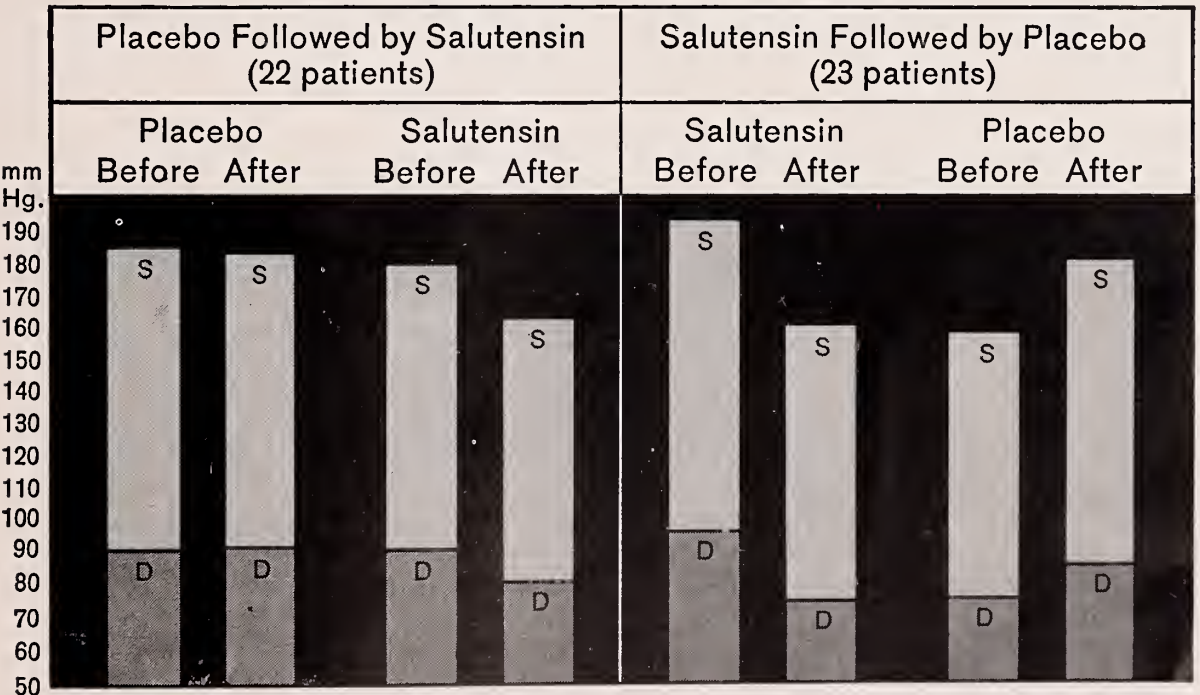
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A "DOUBLE BLIND" CROSSOVER STUDY

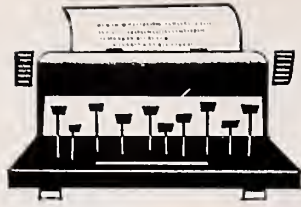
Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this "double blind" crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)

BRISTOL LABORATORIES/Div. of Bristol-Myers Co., Syracuse, N.Y.





editorials

Charles Raymond Arp

RAYMOND ARP, M.D., practicing internal medicine in Atlanta, died October 6, 1961. His death is a loss to the profession and the Medical Association of Georgia of which he was treasurer for the past two and a half years.

Dr. Arp will be well remembered by his family,

friends, community, and medical colleagues for his contributions in behalf of others. His monument was hewn of selflessness and tireless efforts in the interest of those around him. This memorial was fashioned by his acts during his brief life span and while saddened at his death, we gather strength from his spirit which remains with us all.

Stress Urinary Incontinence

THE SECOND MOST DISTURBING bladder dysfunction is stress urinary incontinence; the first being that caused by infection. The severity and tolerability of stress urinary incontinence vary so widely that only careful questioning of the patient and thorough examination can accurately assess the situation. It is so frequently a sequel to child birth trauma that an amazing number of women will accept a really troublesome amount of incontinence thinking it a part of "the price to pay" and not know that a relatively simple repair will cure or greatly improve the situation. Apparently half of multiparous patients when questioned directly will admit a varying amount of stress urinary incontinence. Many will, without surprise, say "Oh, that ! ? !" Certainly all these

patients who have stress urinary incontinence neither desire nor need any corrective measures. It may occur only on rare occasions, causing no discomfort or embarrassment. Some patients themselves will have solved the problem tolerably by "not waiting until the bladder gets too full," or by exerting some voluntary control by crossing the legs, contracting the levatores ani muscles, etc. Others, however, are so plagued by the embarrassing leakage that they must wear some constant protection, or even become a virtual recluse.

Certainly this troublesome situation has been affecting women as long as babies have been born. It is interesting, historically, to review the numerous and widely varied therapeutic efforts that have been

tried throughout the ages. It can be said that practically every conceivable physical, chemical and surgical measure has been tried and none, to this day, has been completely successful. At first, various types of vaginal pessaries and supports were tried; then injection of sclerosing materials in the periurethral tissues; cauterization of portions of, or the entire length of the urethra and trigone, and even encirclage of the urethra with nonabsorbable materials. Tonics with strychnine, quinine, etc., "to increase muscle tone" were tried and without success.

Finally definitive surgery was resorted to; first by Schultz in 1878. Since that time many procedures with numerous modifications have been tried with increasing success. At the present time we know that properly chosen surgery gives the best chance for successful correction for stress urinary incontinence. Muscle exercises may help in some cases, but surgery is our chief weapon.

There are basically three types of surgical procedures used; namely (a) those directed at the periurethral tissues with the effort to plicate the weakened structures (Kelly technique). (b) Those directed at augmenting urethral support by extrinsic tissue (Goebel-Stoeckel sling procedure). (c) And those directed in repositioning the urethra to its more normal or exaggerated retropubic location. (Marshall-Marchetti-Krantz procedure). The various

modifications of these basic procedures are nearly as numerous as the surgeons who use them. It even gets to a point of absurdity when a surgeon will attempt to attach his name to a fundamental procedure simply because he may choose a different type of suture, clamp, or indeed, stand up to operate when his predecessors have sat down, or vice versa.

Stress urinary incontinence is a subjective complaint and therefore correction of this should be postponed as a general rule until the patient herself is convinced that such correction is needed. Then the pelvis and urinary tract should be thoroughly evaluated to determine if the case is a true stress incontinence or some other condition, such as neurogenic weakness, anomalous urinary tract anatomy, inflammation, etc.

The patient should understand that no surgical procedure for this condition is absolutely dependable and that if the first attempt should fail or give less than the hoped for improvement, a subsequent procedure of another sort may have to be resorted to.

Stress urinary incontinence is a very common ailment of women; also it is a widely tolerated ailment. However, when the condition gets too troublesome, it can be improved or cured in most cases by a relatively innocuous procedure or procedures.

*John H. Ridley, M.D.
1211 W. Peachtree St., Atlanta*

Hall County Medical Society Sponsors Health Fair

THE HALL COUNTY MEDICAL Society deserves the hearty praise of all physicians in the state for the highly successful health fair which they sponsored in Gainesville on October 11-12. This was the second such effort within the state in recent years, the first Fair having been held by the Cobb County Medical Society in 1956.

Some 15,000 people visited the Gainesville exhibits within the two day period. The enthusiasm of the visitors is confirmed by the fact that more than a 1,000 blood typing procedures and more than a 1,000 vital capacities were performed. Fourteen hundred people at the Fair availed themselves of free chest x-rays. The keen interest of the visitors was especially evident at the simulated surgical

operative demonstrations.

Such health fairs are most effective as a public service project for any county society. Its over all impact in the public relations area can never be finally measured but it is great as the members of the Hall County Society will attest.

This is borne out by favorable newspaper and radio comments as well as the scores of complimentary telephone calls received by Hall County physicians from interested citizens.

This is a worthwhile project for all County Medical Societies. It is hoped that many more are planned and that the Fair Committees of the Hall and Cobb Societies will be consulted freely for advice in staging such Fairs in the future. These men have amply demonstrated that they have the know how.

Early Diagnosis of Carcinoma of the Lung

ACCORDING TO OCHSNER, H'Doubler and Blalock (from the Ochsner Clinic New Orleans) lung cancer is increasing in both sexes more than any other cancer and is fast becoming the most common cancer. Bronchogenic cancer also involves both lungs with equal frequency. It appears to be more common in the upper lobes. The correlation between the smoking of cigarettes and carcinoma of the lung appears to be more and more definitely established by all dependable investigators.

Certainly if a person is a smoker he should have chest x-ray films taken every six months to diagnose symptomless pulmonary lesions before metastases occur. If a cough develops and persists for over three to four weeks or there is a change in the nature of the so called "smokers morning cough" and this person is over forty years of age, a complete chest evaluation should be made by a competent physician. This investigation should include a chest film, together with a thorough history and physical examination. If there is any doubt, a bronchoscopic examination should be performed even though the chest x-ray film is not diagnostic. Carcinoma of the lung begins insidiously and often times only partial obstruction will be caused by a small centrally located lesion, and the general configuration of the chest x-ray film will not be remarkable.

At the time of bronchoscopy a very careful examination of all the orifices that can be seen should

be done, and this would definitely include the use of the auxiliary lenses including a right angle telescope and if possible the fore-oblique and retrograde lenses. If these examinations are again not diagnostic then bronchography should be done. A third or fourth division bronchus can be partially occluded and this occlusion can only be definitely discerned with the use of the bronchogram.

Many series have been reported where the five-year survival rate following resection has ranged from 20-30 per cent. One series reports a five-year survival rate of 42.9 per cent in patients with localized growths as compared with 6.2 per cent for those with extension. The asymptomatic, localized, peripheral round lesions present a five-year survival of 76 per cent. In the symptomatic peripheral lesions, however, the survival rate after resection drops to 36 per cent.

A high index of suspicion should prevail if there is any doubt whatsoever and an assiduous effort should be made to determine the presence or absence of the so called stenosed bronchus syndrome. If the patient is a suitable candidate for exploratory thoracotomy and all other diagnostic techniques have been exhausted and there is still a strong suspicion of the possibility of cancer, then a thoracotomy should certainly be done. It is only through this conscientious approach that more favorable results will be obtained in the surgical management of bronchogenic carcinoma of the lung.

The State Aid Cancer Program

THE GEORGIA STATE AID CANCER PROGRAM was initiated in March, 1937, under house bill #473, entitled "Cancer Prevention and Care." This bill provided that the funds for this program should come from that part of the general appropriation funds allotted to the State Board of Health. It further provided that the State Board of Health be in charge of the administration of the program. The original

grant was for \$50,000.00. The present yearly budget is \$400,000.00. The fiscal year is from July to July.

In the past the hospitals connected with the program have been paid 70 per cent of the estimated cost on a per diem basis. On July 1, 1961, this was raised to 100 per cent of actual cost but no change has been made in the budget. The raise in the amount paid the various hospitals plus a 20 per cent rise in

case load over the previous years means that roughly \$215,000.00 will be added to the cost of the program for the year 1961-62. This means that the cost of the program will be at least \$600,000.00. The present budget will permit operation of the program until March 1, 1962, but it will be necessary to stop accepting new patients January 1, 1962. Those funds available will be used for continuing the treatment of patients already accepted.

Georgia's State Aid Program has won praise all

over the nation. It would be a tragedy if this program has to be halted within the next two or three months. If the physicians of Georgia contact their Senators and Representatives to let them know the actual status of this program, it might be possible to secure additional funds. Please give this your careful consideration.

*Robert C. Pendergrass, M.D., Chairman,
Sub-committee on Cancer
Medical Association of Georgia*

AMEF CONTRIBUTORS

<i>Name</i>	<i>Address</i>	<i>Name</i>	<i>Address</i>
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Eisen, Bruno	Atlanta	Patton, Samuel E.	Macon
Fokes, Robert E., Jr.	Moultrie	Smith, Leo	Waycross
Gray, A. R.	Rome	Simmons, Mack	St. Simons Island

ALLERGIC REACTORS STUDIED

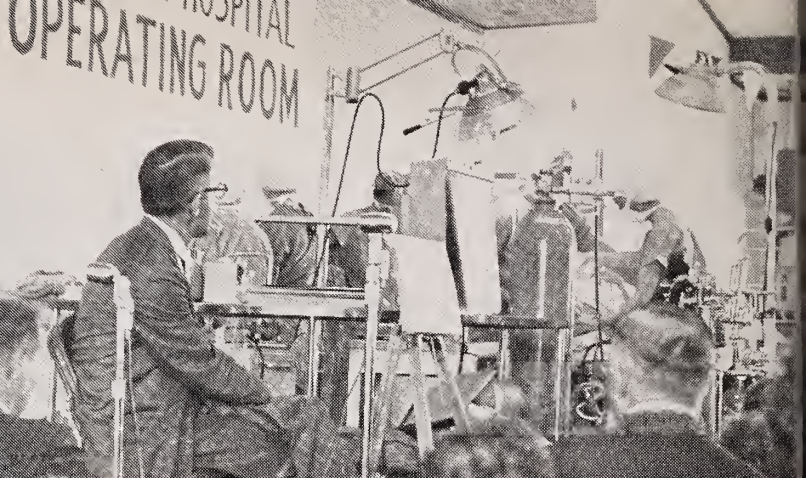
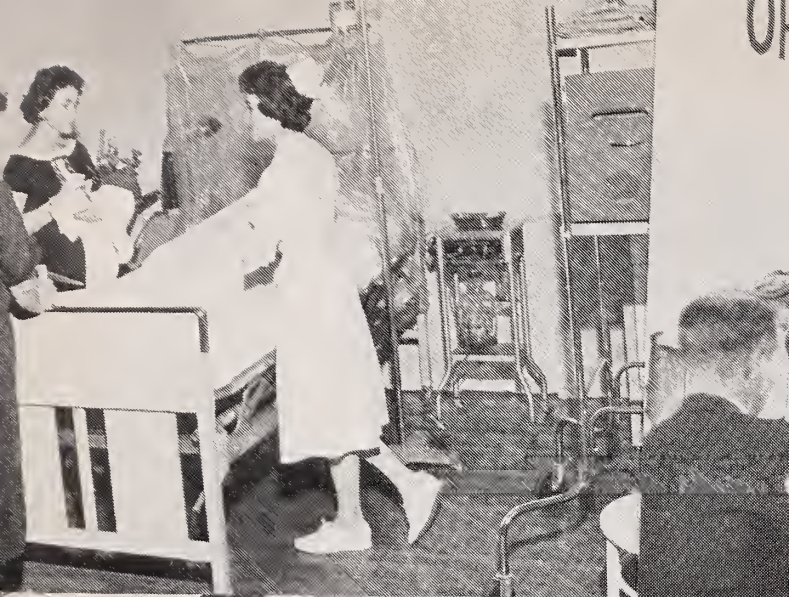
The American Academy of Allergy is studying the history and treatment of allergic reactors to insect stings. Both unusually large local reactions and systemic reactions are of interest. The study is conducted by volunteer physician members of The Academy without cost to the patient. Cooperating patients will be sent a wallet-size card to alert medical personnel to the possibility that a sudden severe illness might be caused by insect sting allergy.

The Academy wishes to compile a list of several thousands of persons allergic to insect stings and would like to follow up this list with a questionnaire to be filled out by the patient. A follow-up annual inquiry of the patient will be made as to whether he has been stung during the year, by what type of insect, if known, and with what results. They anticipated that some of these patients will have had no immunization for stinging insects, some will have had a few immunizing doses and some may be treated with a long term course of hyposensitization. By comparing the subsequent sting history of persons in these various categories they hope to learn the most desirable therapeutic course to follow.

At this time no one knows for sure how much treatment should be given—or even what happens to the majority of these people if they remain untreated. Of course we all are aware of the acute near-fatal and fatal reactors. But is their incidence in a known sensitive group high or low? Likewise we do not know whether the patient who has extraordinarily large or persistent local reactions to insect stings has a high or a low risk of developing anaphylactic reaction on subsequent stings.

It would be much appreciated if you would send us the names and addresses of persons who show either severe local or generalized allergic reactions to insect stings, *for this research purpose*. Such patients will be contacted with a questionnaire. The physician in charge of the patient will, of course, continue to supervise his care.

The Insect Research Committee representative for your area is Dr. William G. Tyson for the southern half of Georgia, at 4581½ West Broad St., Savannah, and Dr. Carl C. Jones, Jr. at 1293 Peachtree St., N.E., Atlanta 9, for the northern half of Georgia.



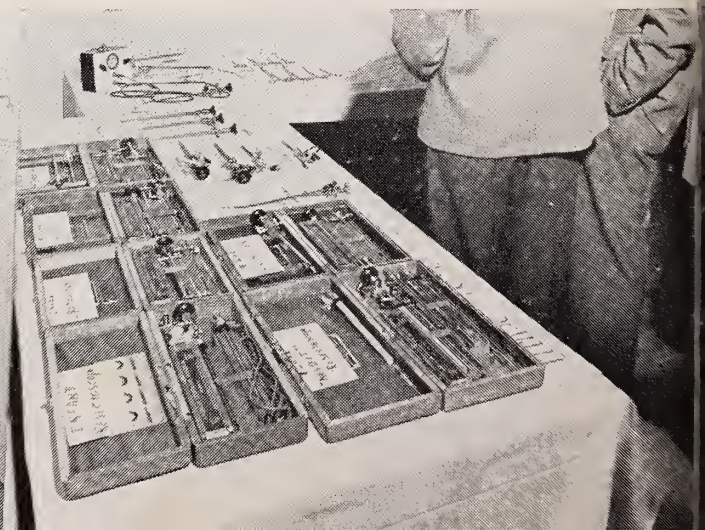
Hall County

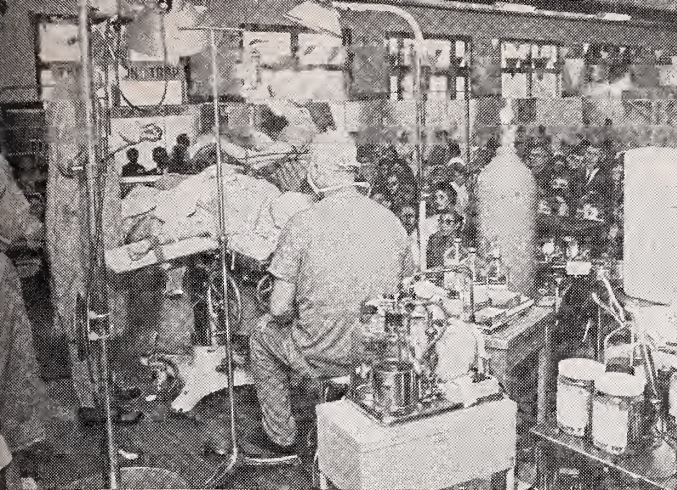
It was not the usual type of carnival with rides and home canned foods, but an informative affair with 33 exhibits to interest the general public in medicine and related medical fields.

This health fair was sponsored by the Hall County Medical Society on October 12-13 at the local Civic Building in Gainesville. The ribbon cutting exercise was at 10:00 a.m. the opening day and Mayor Milton J. Hardy did the honors. Other speakers were W. D. Stribling, III, M.D., General Chairman of the Hall County Health Fair; H. S. Jennings, Jr., M.D., president of the Hall County Medical Society; and Linton Bishop, M.D. of Atlanta who represented the Medical Association of Georgia as acting president.

Over 15,000 people attended the two day stand. Exhibits were set up by the Health Department, Hall County Hospital, the Gainesville Fire Department, the National Aeronautics and Space Administration, the Hall County Dental Society, Lockheeds and many similar groups.

In the main meeting room were booths displaying many fields of medical practice from Anesthesia to Urology. At each display one could find a doctor to explain the equipment or answer any questions pertinent to his field.





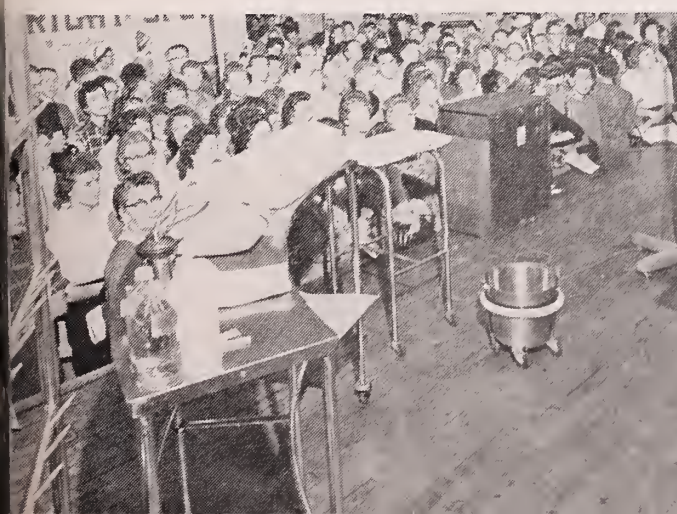
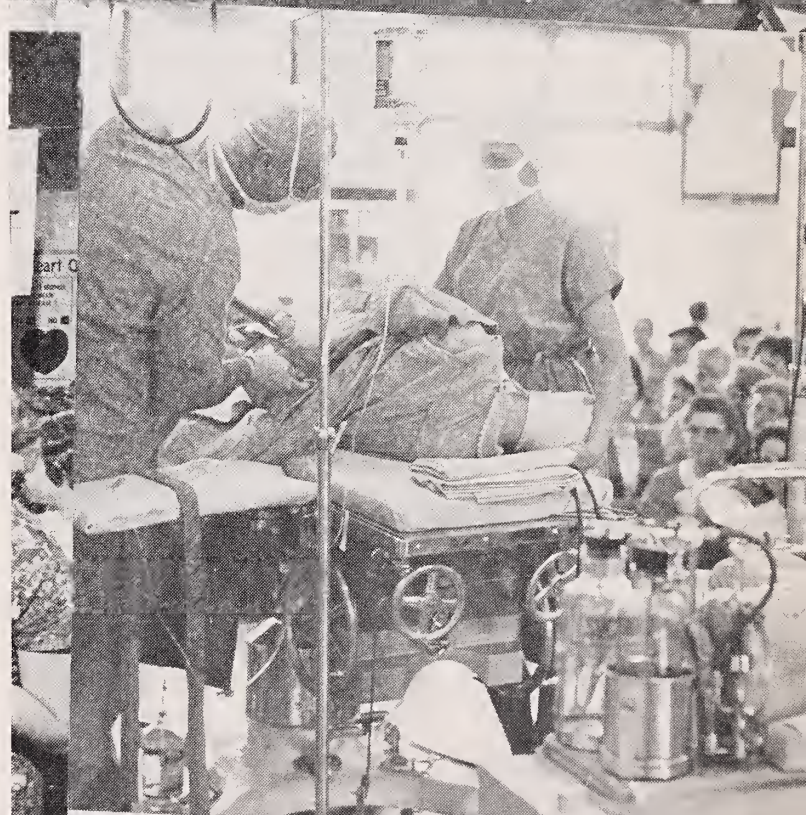
Health Fair

The main attraction, a mock operating room, was located on the stage at the end of the hall. Three times a day a simulated operation took place (Cesarean section, gastroectomy, and appendectomy). The equipment was from the Hall County Hospital and every detail was authentic. At the scheduled hour the nurses assembled the operating room equipment and then went out to scrub and returned with the doctors and began the procedure for the particular operation of the hour. A running commentary helped the audience to understand different techniques.

Films were shown continuously in the projection room at the far end of the auditorium. Many subjects were covered including heart diseases, high blood pressure, circulation, cigarettes, training the medical student, alcohol, etc.

As a public service approximately 1,400 chest x-rays were taken and 1,000 people had their blood typed. Outside the main building were displayed a chest x-ray unit, a fallout shelter, and an ambulance. The hospital Auxiliary distributed 10,000 soft drinks free of charge.

The Hall County Medical Society has received much praise for their hard work and for the interest in medicine aroused in the citizens of Hall County.



1961-62 CALENDAR OF MEETINGS

State

- Nov. 30-Dec. 1—Annual Postgraduate meeting sponsored by the Department of Ophthalmology, Emory University School of Medicine, Grady Memorial Hospital Auditorium, Atlanta.
- Jan. 23-25—Obstetric Problems In Private Practice, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- Feb. 13-15—Cardiac Emergencies, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- Feb. 18-21—Atlanta Graduate Medical Assembly, Atlanta Biltmore Hotel, Atlanta, Georgia.
- Mar. 20-22—Pre and Postoperative Care, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- April 2-4—Augusta Postgraduate Medical Assembly (Coincides with practice rounds of the Masters Golf Tournament) Augusta.
- May 6-9—Annual Session, Medical Association of Georgia.**

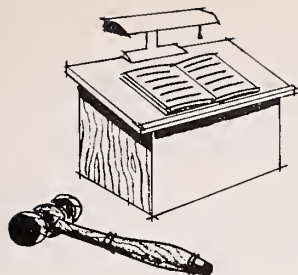
Regional

- Dec. 5-7—Southern Surgical Association, Hot Springs, Virginia.
- Mar. 5-8—Southeastern Surgical Congress, Louisville, Ky.
- Mar. 12-15—New Orleans Graduate Medical Assembly, The Roosevelt Hotel, New Orleans.
- Mar. 18-21—Missouri State Medical Association, St. Louis.
- Mar. 26-28—American College of Surgeons, Sectional Meeting, Hotel Peabody, Memphis, Tenn.
- April 8-11—Tennessee State Medical Association, Peabody Hotel, Memphis, Tenn.
- April 23-25—Annual Meeting West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Virginia.
- April 26-28—Alabama, Medical Association of the State of, Tutwiler Hotel, Birmingham, Ala.
- April 29-May 2—Arkansas Medical Society, Arlington Hotel, Hot Springs, Ark.
- May 5-9—Medical Society of North Carolina 108th Annual Meeting, Sir Walter Hotel, Raleigh.
- May 7-9—Louisiana State Medical Society, Hotel Frances, Monroe, La.
- May 8-10—Mississippi State Medical Association, Hotel Heidelberg, Jackson, Miss.
- May 8-10—South Carolina Medical Association, Ocean Forest Hotel, Myrtle Beach, S. C.
- May 9-13—Florida Medical Association, Americana Hotel, Miami Beach, Bal Harbour.
- May 12-15—Texas Medical Association, Austin, Tex.

National

- Dec. 2-7—American Academy of Dermatology and Syphilology, Palmer House, Chicago, Illinois.

- Dec. 4-8—American College of Chest Physicians, Postgraduate Course, Statler-Hilton Hotel, Los Angeles, California.
- Dec. 7-9—New York Academy of Sciences Conference on the Cervix, The Barbizon-Plaza Hotel, New York City.
- Dec. 8-10—American Psychoanalytic Association, Biltmore Hotel, New York City.
- Dec. 9-10—Academy of Psychoanalysis, Hotel Commodore, New York City.
- Jan. 17-19—Tenth Postgraduate Course, American Diabetes Association, The Statler Hilton, Detroit, Mich.
- Jan. 18-20—American Society of Clinical Radiology, Arizona Biltmore Hotel, Phoenix, Ariz.
- Jan. 19—American Society of Facial Plastic Surgery, Hotel Elysee, New York City.
- Jan. 27-Feb. 1—American Academy of Orthopaedic Surgeons, Palmer House, Chicago.
- Feb. 5-7—American Academy of Allergy, Denver-Hilton Hotel, Denver, Colorado.
- Feb. 7-9—American Academy of Occupational Medicine, Pittsburgh-Hilton Hotel, Pittsburgh, Pa.
- Feb. 7-10—American College of Radiology, Roosevelt Hotel, New York, New York.
- Feb. 8-10—Society of University Surgeons, Cleveland, Ohio.
- Mar. 20-23—American Association of Anatomists, Minneapolis, Minn.
- March 21-24—Neurosurgical Society of America, Buena Vista Hotel, Biloxi, Mississippi.
- April 1-6—American College of Allergists Graduate Instructional Course and 18th Annual Congress, Hotel Radisson, Minneapolis.
- April 2-14—Postgraduate course in Laryngology and Bronchoesophagology, University of Illinois College of Medicine, Chicago.
- April 2-5—American College of Obstetricians and Gynecologists, Palmer House, Chicago, Illinois.
- April 6-13—American Academy of General Practice, Las Vegas, Nev.
- April 23-28—American Academy of Neurology, Statler-Hilton Hotel, New York City.
- April 30-May 2—American Academy of Pediatrics, spring meeting, Statler-Hilton, New York City.
- April 30-May 3—American Proctologic Society, Deauville Hotel, Miami Beach.
- April ——American Association of Pathologists and Bacteriologist, Queen Elizabeth Hotel, Montreal, Canada.
- May 6-10—American Association of Plastic Surgeons, Hotel Del Coronado, Del Monte, Calif.
- May 28-30—American Ophthalmological Society, The Homestead, Hot Springs, Va.
- May 29-June 2—American College of Cardiology, Denver Hilton Hotel, Denver, Colo.



president's letter



FRED H. SIMONTON, M.D.

POISON CONTROL CENTERS

FIGURES RECENTLY COMPILED by the Georgia Department of Public Health reveal that 60 persons died as the result of poisonous substances during the year 1960.

The U.S. Public Health Service has estimated that 600,000 children, give or take a few, will swallow some type of poison during a given year and that of this number 500 will die from its effects.

Recent studies on the toxicity of chemical products used in the home and for commercial use indicated that approximately 80 percent of these contained poisonous substances in varying degrees.

From these three bits of scattered information one can readily see the necessity and the wisdom of providing some type of control center to minimize the effects of accidental poisoning. Indeed, the Congress itself, concerned over this needless menace to health and lives of the people passed a House Joint Resolution (H. J. Res. 358) during the recently concluded First Session of the 87th Congress proclaiming the third week in March of each year to be National Poison Prevention Week.

The National Clearinghouse for Poison Control Centers under the U.S. Public Health Service has aided in the establishment of Poison Control Centers strategically located throughout the several states.

In 1959 the Georgia Department of Public Health set up a network of poison control centers to serve as

an information clearinghouse for physicians. At the present time there are 10 control centers operated out of hospitals so located as to be readily available to physicians in every part of the state. Poison Control Centers in Georgia are located as follows:

<i>City and Hospital</i>	<i>Telephone Number</i>
Albany Phoebe Putney Memorial Hospital	HEmlock 6-5741 Ext. 259
Athens Athens General Hospital	Liberty 8-4121
Atlanta Grady Memorial Hospital	Jackson 3-4711 Ext. 567
Augusta The University Hospital	PArk 2-7731 Ext. 233 or 405
Columbus The Medical Center	FAirfax 2-2521 Ext. 221
Macon Macon Hospital	SHerwood 2-1441 Ext. 314 or 231
Rome Floyd Hospital	234-1014 Direct Line
Savannah Memorial Hospital	ELgin 5-3200 Ext. 291
Valdosta Pineview General Hospital	CHerry 2-3450 Ext. 26
Waycross Memorial Hospital	ATlas 3-3030 Ext. 33

The purpose and function of these Poison Control Centers is to provide information to physicians on a moments notice to combat the effects of any poisonous substance which a patient may have taken.

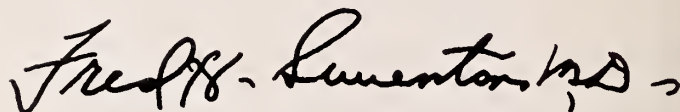
To accomplish this objective a card file on trade name products, including drugs known to contain

PRESIDENT'S LETTER / Continued

toxic materials, is maintained at each of the Poison Control Centers. Thus when a physician needs to know the chemical contents of a given substance and an effective antidote with which to minimize its effects, a call to any of Georgia's 10 Centers will produce fast results.

Each Center is organized to give 24 hour, around-the-clock telephone service to physicians. Each is

prepared to answer questions regarding drugs, insecticides, cleaning compounds and other substances which may be toxic and to counsel with the calling physician on appropriate treatment.



President, Medical Association of Georgia

LOCKHEED EMPLOYS 300 CARDIACS IN THE GEORGIA DIVISION

Lockheed's Georgia Division, which has approximately 10,000 employees, has placed almost 300 cardiacs on jobs, the Georgia Heart Association was told in Atlanta.

Eugene Mattison, director of industrial relations at Lockheed, participated in a panel discussion presented by the Georgia Heart Association at the request of the President's Committee on Employment of the Physically Handicapped.

"We have had good experience with cardiacs who are properly placed on jobs," Mattison reported. "We believe it's ability, not disability, that counts."

He said the 300 out of 10,000 employees compare closely with recent reports on the frequency of cardiac cases generally. Cardiacs represent a large percentage of those disabled. They include present employees who became cardiacs, and applicants for employment who are cardiacs.

Mattison declared that the problem of compensation coverage for cardiacs must be solved if employment avenues are to be opened to them.

"Let's look at the case of the applicant for work who is a cardiac," Mattison said. "Industrial management is cognizant of the fact that many cardiacs are employable. Some of them can perform fairly strenuous physical activity. Others may perform less strenuous jobs for many years without deleterious effect to themselves.

"Management must, however, take into consideration the cost of employing the cardiac. Many rulings of compensation boards in recent years granted full compensation to known cardiacs who die quietly in bed, at home, frequently on a week-end. We all realize that it is inevitable that a cardiac disease will terminate in death, if an automobile accident or other disease does not kill the patient first. Management considers it unjust to be penalized finan-

cially because of the mortality of man. A solution to the problem of compensation coverage for cardiacs is necessary if employment avenues are to be opened to them," Mattison pointed out.

"Most employers feel it is the company's responsibility to care for its regular employees who become physically impaired, even though this may mean putting the handicapped workers in a less exacting or less desirable position," the Lockheed official went on.

The Lockheed industrial relations director said the number of employees with physical limitations who can be employed in any one plant, with efficiency, is necessarily limited.

"The increasing age of all employees means that a certain percentage of these employees will develop some type of cardiovascular disease," Mattison commented. "Many companies feel a moral obligation to continue employment of these old employees who have developed physical limitations. It then becomes obvious that the number of physically limited new hires must be held to a minimum. Many less strenuous jobs are held for older employees who develop disabilities because of injuries, illnesses, and the ravages of increasing age."

"The employer also has a responsibility to insure a profitable operation and thus job security for all its employees, as well as financial security for the stockholder's investment," he said. "Competitive businesses cannot and should not employ the handicapped out of charity.

"The employer also has a responsibility for the safety and welfare of all its employees through the observance of a high degree of industrial safety. While return of the worker to his regular job might be desired by the physician, the employer must be sure the cardiac can perform his regular task in a manner safe to others.



legal page

CONTRACT WITH WELFARE DEPARTMENT

John L. Moore, Jr., *Atlanta*

THE MEDICAL ASSOCIATION of Georgia has recently entered into a contract with the Georgia Department of Public Welfare. Under the contract the Association is to provide advice to the Department on the medical aspects of planning and administering a program for the payment of costs of limited hospitalization of the approximately 100,000 Georgians over 65 years of age who are on the Welfare rolls. In addition, the Association will assist the Department in processing the medical portions of claim forms submitted by hospitals approved for the program.

Thus, Georgia is joining the growing number of states which are implementing the Kerr-Mills legislation of the 1960 Congress. The legal background of this program should be of interest to Georgia physicians as they assume responsibility for admitting aged patients to hospitals and as their Association helps to make the whole program run smoothly.

In the early days of the New Deal Congress passed the first legislation providing federal matching funds to states for the purpose of making welfare payments to needy aged persons. Other programs provided at the same time matching funds to states for unemployment compensation administration, aid to dependent children, maternal and child welfare, the permanently and totally disabled, and for aid to the blind.

Later Congressional amendments have extended these programs to provide matching funds to state programs for medical and hospital expenses for the aged (Kerr-Mills Law). The structure of all of these programs is similar. Federal funds in percentages

varying according to factors of program, wealth of state, and population, are made available to match state funds if the state adopts a plan for one or more of the programs. Federal law sets the broad outlines of the program and the state must fill in details in a plan which must be federally approved.

The Georgia General Assembly has adopted necessary enabling programs, usually from one to two years after the federal legislation, for old-age assistance, needy blind persons, dependent children, and, in 1961, for medical assistance for the aged.

The federal statutes require that the state designate a single state agency to administer all programs mentioned in this article. Georgia has designated the Department of Public Welfare. Since 1953, the Department of Health, Education, and Welfare has been the federal agency in charge of the administration of these programs. HEW's interpretation of the federal statutes is to the effect that the Georgia Welfare Department may not delegate any of its administrative functions to other agencies, public or private, but may solicit advice of others.

When the enabling legislation in Georgia to take advantage of the Kerr-Mills Law was considered, it was realized that medical expertise would have to be available to the Georgia agency responsible for administering the program. This the Welfare Department did not have. The Medical Association of Georgia proposed legislation reconstructing the Welfare Department to place in it a Welfare Board similar to the State Board of Health. However, the bill as passed by the 1961 General Assembly did not incorporate this idea. Instead, it authorized the Wel-

fare Department to contract with the State Health Department or any other agency for necessary aid in administering the program of medical assistance to the aged.

The Welfare and Health Departments were unable to agree on a contract so the Welfare Department approached The Medical Association. From negotiations has come a contract for the supplying of medical expertise within the limitations placed by federal

statutes and HEW's interpretations of them.

It is to be hoped that the new program, commencing January 1, 1962, and supplying payment for limited hospitalization for certain diseases as to persons over 65 years of age who are on the welfare rolls, will be a great success. Physicians in Georgia should be proud that their Association has taken a leading part in sponsoring the federal and state legislation, in encouraging the State of Georgia to make funds available, and now in helping to the maximum extent it can in the planning and administration of the hospital program.

Prepared at the request of the Medical Association of Georgia. Mr. Moore is a member of the firm of Alston, Sibley, Miller, Spann, and Shackelford, general counsel for the M.A.G.

Remember These Dates for Your Calendar

MAY 6-9, 1962

These are the dates for the

ANNUAL SESSION

of the

**MEDICAL ASSOCIATION
OF GEORGIA**

to be held in

SAVANNAH, GEORGIA



heart page

UNILATERAL RENAL DISEASE

Henry Randall, M.D., *Marietta*

THE RELATIONSHIP OF RENAL disease to arterial hypertension has interested clinical investigators and practicing physicians for many years. After Goldblotts description of the production of arterial hypertension in the dog by placing a clam to partially occlude the renal artery, this interest increased and many kidneys were removed from hypertensives in spite of the fact that no rational basis for selection of suitable candidates for nephrectomy existed. The results were to say the least disappointing.

Primary renal hypertension due to parenchymal renal disease and renal artery lesions does exist, however. We are all familiar with the association of hypertension and chronic glomerulonephritis and pyelonephritis. Occasionally this pyelonephritis is unilateral, but in general, results of nephrectomy for unilateral parenchymatous renal disease have been disappointing.

The greatest interest in recent years has been focused on renal hypertension associated with unilateral renal arterial disease. The most common lesions of the renal artery are intrinsic in nature. Of these atherosclerotic lesions are the most common. Most frequently this consists of an atherosclerotic plaque protruding into the arterial lumen resulting in partial occlusion. Thrombosis and embolism also occur. Other intrinsic defects are less common and include congenital stenosis, mycotic aneurysm of the renal artery, multiple renal arteries with stenosis or occlusion, and thromboangiitis obliterans.

Extrinsic causes of occlusion are not common but consists of such things as pressure from tumor,

fibrous bands, aneurysm of abdominal aorta, torsion and kinking of the renal artery, trauma and scarring.

Our knowledge has reached a state in recent years which allows us to choose with some accuracy those patients who will benefit from nephrectomy. It must be emphasized, however, that no test or group of tests allows anything like 100 per cent accuracy in detecting those who will be cured of hypertension.

Since we see large numbers of hypertensive patients in the practice of medicine, and individuals with curable hypertension due to renal artery disease are not common, we need to examine those factors which should lead us to the diagnosis. Some of the factors which have proven helpful include:

1. The history of flank pain of brief duration immediately preceding the occurrence of a rather severe hypertension.
2. The sudden occurrence of severe or malignant hypertension in a person in the middle or elderly age group.
3. Any hypertensive patient whose previously mild hypertension suddenly becomes severe.
4. A patient with a disparity in size or excretory function of the two kidneys as demonstrated by intravenous pyelography.
5. Very young hypertensives without a family history of hypertension or chronic parenchymatous renal disease.

Diagnosis of unilateral renal artery disease depends primarily on renal arteriography. This is usually done by the injection of a high density radio-

pague dye into the abdominal aorta above the origin of the renal arteries by means of a translumbar percutaneous puncture. This procedure is attendant with some morbidity and mortality and must be done only by those with experience in the proper technique. Another means of obtaining a renal arteriogram is by retrograde catheterization of the aorta from the femoral artery. A small polyethylene catheter is threaded through a large needle inserted into the femoral artery and in this manner excellent opacification of the renal artery obtained. This method has begun to become more widely used recently. Renal arteriography is not without its shortcomings, however, and false positive and false negative results are not uncommon.

In patients with unilateral renal artery obstruction studies of differential excretory function of the kidneys by means of ureteral catheters may be helpful. It has been shown that there is a decrease in sodium excretion and increase in urine osmolarity on the affected side. In cases in which arteriography is not readily available this type of study may prove helpful in the selection of patients for further study.

Another means of selection suggested by Brust and Ferris is the use of intravenously injected Tetraethylammonium Chloride (TEAC). They reported a pressor effect or no appreciable fall in the blood pressure of the vascular group whereas in those with parenchymal disease there was a large fall in blood pressure. This test has not proven reliable in a high percentage of cases, however, and cannot be relied on prognostically.

The decision as to the best means of treatment is not always clear, even when we feel relatively sure that we are dealing with hypertension of unilateral renal origin. This is due to the fact that in the past decade potent drugs for the control of hypertension have come into widespread use, and we can justify surgery only if it proves to be highly successful and attended with a low mortality rate. As yet this is not the case. In the elderly patient, or any patient with a coronary or cerebral atherosclerotic disease, at present it would seem that medical management has the greatest merit. Also in those with severe renal dysfunction medical management seems prudent. In the young hypertensive with renal artery disease the surgical approach is advisable in order to effect a cure.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

"DOCTOR DIPLOMATS"

Five physicians from Tulsa, Oklahoma, members of the First Presbyterian Church of Tulsa, are giving up their practices for six-week periods to serve voluntarily at the Miraj Medical Center in Miraj, India.

Dr. C. S. Lewis, one of these five Tulsa physicians, recently reported to the A.M.A. on the progress of the project labeled "Doctors in Asia."

The first of the group of volunteer physicians flew to Miraj in mid-August. He returned at the end of September and the next doctor made the trip. In all, the five physicians will donate a total of thirty weeks to the program. The project is endorsed by the Tulsa County Medical Society. Funds for medical equipment, transportation and other expenses were raised through church and public contributions.

Other groups of American physicians are also becoming interested in the possibility of initiating a similar venture in their own communities. For example, several doctors met with Doctor Lewis during his A.M.A. visit to discuss the feasibility of adopting an

overseas program which would provide medical care to another area of the world equally in need of such assistance.

Still another example of American physicians demonstrating their interest and willingness to serve in foreign mission fields on a temporary basis is shown by the large number of doctors who have written to the A.M.A. Department of International Health in the last few months to inquire about such service. This new Department administers a program approved last June by the A.M.A. House of Delegates whereby members of the A.M.A. may volunteer for service in the foreign mission fields on a temporary basis when emergencies arise. Cooperating with A.M.A. in this program are missionary agencies representing every denomination sponsoring American medical missionaries.

Physicians interested in volunteering for such service are asked to write directly to the A.M.A. Department of International Health, 535 N. Dearborn Street, Chicago 10, Illinois.



mental health page

... TO COMFORT ALWAYS

Leonard T. Maholick, M.D., *Columbus*

IN OUR NEVER-ENDING battle against disease (L. *dis + aise*, meaning lack of ease, or discomfort), we physicians are proud of our manifesto "To cure sometimes, to relieve often, to comfort always." We take pride in our growing body of scientific knowledge aimed at reducing suffering and prolonging life. However, our finest technology comes to a precipitous halt when we are forced to cope with such imponderable questions as: what to do when confronted with a patient having an incurable disease, chronic suffering of any kind, a terminal illness; what to do when there are no more tests to run, when the last drug has been administered and failed, when the operation was a success but the patient has not recovered; what to do about death itself for it is inescapable and incurable. At these points, and others, the gentle art in the practice of medicine dawns on the horizon and scientific medicine recedes into the background. In spite of all our technological victories—past, present, and future—I rather doubt we shall ever get rid of the patient. Someone will always need to understand, counsel, and comfort him.

To comfort is a magnificent responsibility shared by only a few outside our profession. It is an ever-present, haunting challenge to help our patient take a meaningful stand against the suffering which surrounds him. Existential philosophy, particularly the concepts of Dr. Viktor Frankl, Viennese psychiatrist, sheds much light on this subject^{1,2}. According to

existential views, man is essentially a free, responsible being who has built into him the capacity to withstand and accommodate to great stress, both outer and inner; is capable of the unexpected as well as the expected; an unpredictable, yet predictable. Many physicians have seen these potentials come forth when a patient made a "miraculous" recovery in spite of the known data indicating otherwise. These reserves are present in our patients waiting to be activated in a time of need, but we should be consciously alert to them in order to bring them to their fullest expression.

Even in the face of an apparently hopeless situation any patient still has a margin of freedom within which to move. He can make choices; he can decide to change, modify, or not change his attitudes; he can accept or reject his fate. It is quite conceivable that he can thereby achieve fulfillment and meaning to his existence in its highest sense through the manner in which he faces suffering and death.

Man does not necessarily refuse to suffer, but he does not want to suffer in vain. Man is willing to suffer and can accept this, but it must have meaning.

To comfort does not always mean we give our patient relief in the usual sense of the word, but rather we attempt to help him discover that his own individual life has meaning, direction, and purpose. Who should be in a better position to do this than

the physician who is ever present at his patient's side, serving him through many of life's crises from birth to death, and whose own life takes on meaning as he daily confronts and is confronted by suffering. To fulfill this role completely, the physician needs an unconditional belief in the ultimate meaning of existence and suffering. We cannot intellectualize or rationalize life. Life, at best, is transitory. I believe it was Einstein who said that the ultimate principle of human existence cannot be achieved by thinking processes but by belief. If we, as physicians, accept this, we are well on the road to transmitting it to our patients.

Stated simply, if we cannot remove the cause or otherwise cure or bring about relief, if all avenues

are apparently closed, there is still hope for our troubled patient—hope in the form of consolation—hope in the form of modifying our patient's attitude toward his particular disease. This change of attitude can become a priceless value which if brought forth and actualized can give comfort to our patient even when his cause might seem hopeless. If, under these circumstances, we can help our patient find a “why” for living, he will find the “how.” Physicians traditionally have held high the values of human life. Perhaps we can find new ways of raising them to greater heights and in the process comfort our patients—always.

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1. Frankl, Viktor E. *The Doctor and the Soul: An Introduction to Logotherapy*. New York: Alfred A. Knoff, 1957.
2. ————. *From Death-Camp to Existentialism: A Psychiatrist's Path to a New Therapy*. Boston: Beacon Press, 1959.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

FILM HIGHLIGHTS OF A.M.A. 110TH ANNUAL SESSION

Medifilm Report III, presenting highlights of the American Medical Association's 110th Annual Meeting in New York City, has been made available to medical and allied groups by Schering Corporation in cooperation with the A.M.A. Department of Medical Motion Pictures and Television.

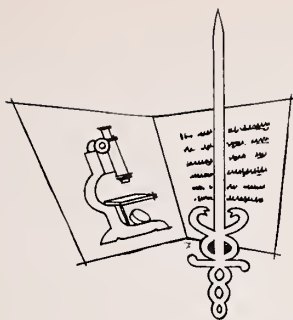
The 33-minute, 16 mm. black and white sound film features scientific exhibits, lectures and panel discussions. Host-narrator is Jeff J. Coletti, M.D., of Old Westbury, N. Y. Interested state and country medical societies may obtain a copy of Medifilm Report III by writing to the American Medical Association, 535 North Dearborn Street, Chicago 10, Ill., or to the Audio-Visual Department, Schering Corporation, Union, N. J.

Of special interest is a demonstration of external cardiac massage at the 1961 Gold Medal Award exhibit manned by Guy Knickerbocker and W. B. Kouwenhoven, both of Baltimore. A mannikin is used

to show the actual technique of closed chest cardiac massage.

Other subjects covered are office management of varicose veins (William Foley, M.D., New York.); electrical anesthesia (James H. Hardy, M.D., Jackson, Miss.); new concepts in diabetes (Howard Root, M.D., Boston, Mass.); rubella in pregnancy (Frank Lock, M.D., Winston-Salem, N. C.); polycystic ovaries (Robert Greenblatt, M.D., Augusta, Ga.); the anxious out-patient (Jackson Smith, M.D., Chicago, Ill.); allergic reactions to drugs (Giles A. Koelsche, M.D., Minneapolis, Minn., and panel members); cine coronary arteriography (F. Mason Sones, Jr., M.D., Cleveland, Ohio); and part time medical mission work (Archibald Fletcher, M.D., India and Glendale, Calif.).

In conclusion, Dr. R. Vincent Askey, outgoing AMA president, speaks on the theme of the 1961 convention—teamwork in medicine.



cancer page

LABORATORY POINTS IN THE DIAGNOSIS OF LIVER CANCER

Jack C. Norris, M.D., *Atlanta*

CANCER OF THE LIVER is usually diagnosed either by a Surgical operation or the autopsy, including the occasional needle biopsy; however, the resort to any of these sources for information is discouraging.

There are a few lab procedures at hand which may be helpful. While they in themselves are not completely determinative, often they can give some degree of indication; something to add to that would make us suspect Liver cancer, otherwise the condition is overlooked. If cancer can be discovered early enough, it is now possible, with improvements in surgery, that solitary lesions can be removed. Dr. George Pack, in New York, and others have made considerable advance along this surgical line of approach. It is remarkable not only how much liver tissue can safely be removed, but also how much of it will regenerate.

A lab performance that has always interested as well as confused us has been the Glucose Tolerance Test, because of its amazing reactions. I specifically refer here to the Hypoglycemic ones, or on the other hand, those tests that suggest hyperinsulinism. We do not really have explanations unless we can demonstrate pancreatic adenomas or other pancreatic acting lesions. There also are those hypoglycemics, which indicate certain other lesions, and those are the tumors not only in the liver, adrenals, etc., but elsewhere in the female organs.

We have been greatly interested in certain observations we have made, and those which others have noted, that in hypoglycemics, Liver cancer may be the cause. It has been shown long ago, by Mann

and McGath of the Mayo Clinic, that the liver and the adrenals are loosely allied in glucose metabolism. When these organs get out of kilter, trouble of a hypoglycemic nature may rapidly develop.

Recently, Lowbeer¹ made an excellent report in the Journal of Clinical Pathology. In a series of these cases in which hypoglycemics were an outstanding feature, there were 48 extrapancreatic neoplasms, and of those 23 were hepatomas of a primary malignant character; not any had apparent relation to the pancreas. In those patients Lowbeer accepts hypoglycemia to have existed whenever the blood glucose level dropped below 55 mgms per cent according to the Folin-Wu method.

Another lab procedure that may suggest liver cancer is the serum enzyme levels, particularly that of transaminase which often shows an increased activity.

To summarize our aids in liver cancer detection, we should therefore keep in mind the following: 1. hypoglycemics of a spontaneous character 2. transaminase increase activity 3. jaundice, with bilirubin increase 4. an active sedimentation rate 5. anemia, mild to moderate 6. moderate increase in Leucocyte count. These procedures found to positively exist in adults of mid-age should always be a signal warning to be on the lookout for LIVER CANCER!

REFERENCES

1. Hypoglycemia Producing Extrapaneatic Neoplasms: Leo Lowbeer: American Journal of Clinical Pathology, Vol. 35, March 1961, No. 3.

Approved by Professional Educational Committee, Georgia Division, ACS.



abstracts by georgia authors

Kaufman, Leo and Cherry, William B., C.D.C., U.S. Dept. Health, Education, and Welfare, Atlanta, Georgia, "Technical Factors Affecting the Preparation of Fluorescent Antibody Reagents," *J. Immunology* 87:72-79 (July) 61.

Interference due to ammonium sulfate contamination of globulin, resulting from the serum fractionation procedure, was eliminated by dialyzing 5-10 ml samples of the antiglobulin in 20/32" diameter dialysis tubing for four hours against two liters of 0.85 per cent sodium chloride. Contamination of *Brucella abortus* antiglobulin by 0.08 M or greater concentrations of ammonium sulfate caused interference with the biuret estimation of the protein and the subsequent conjugation of the latter to fluorescein isothiocyanate. Conjugates prepared in the presence of graded concentrations of the salt showed proportionally greater fluorescence and greater light adsorption values prior to dialysis than did conjugates prepared in the absence of this salt. The results suggested that ammonium sulfate reacted with free fluorescein isothiocyanate to form an unstable dialyzable complex which was more brilliant than the conjugate alone. Ammonium sulfate contaminated conjugates from which salt and free dye were removed by dialysis fluoresced weakly and showed poor staining titers as compared to salt-free controls.

Solutions of fluorescein isothiocyanate stored in the dark at 4° C for 70 days show a marked reduction in fluorescence intensity, whereas the light adsorbing component remained stable. On the other hand, *Brucella melitensis* antiglobulin labeled with fluorescein isothiocyanate and similarly stored for 74 days showed no significant changes in fluorescence intensity. The colorant concentration of the conjugate was similar in stability to that of the fluorescein isothiocyanate solution.

Boling, Edgar, M.D., and Finch, Henry, M.D., 490 Peachtree Street, N.E., Atlanta, Georgia, "Postoperative Complications of Colon Surgery," *South. M. J.* 54:710-714 (July) 61.

The chief problem which confronted the colon surgeon before antimicrobial drugs were available was peritonitis. Today this cause of death has been markedly reduced. A personal series of 161 laparotomies for colon surgery is presented and the post operative complications reviewed. The side-effects of

antibiotics is discussed and the incidence of same is reported in an effort to give each operating surgeon a proper perspective of their value and hazard.

In one case abortion occurred three weeks subsequent to conization and will have to be considered a complication. Hemorrhage was not a significant problem with blood loss ranging from 50 - 350 cc.

Four patients with invasive disease were treated by hysterectomy and radiation. Four patients with carcinoma in situ had total hysterectomies and the remaining seven cases have been followed and are free of disease. Four of these patients have been delivered of eight live infants subsequent to conization.

Conization of the pregnant cervix offers the best means of obtaining adequate tissue for diagnosis and the incidence of hemorrhage and abortion does not make this procedure prohibitive.

McDonald, Harold P., M.D.; Upchurch, Wilborn E., M.D.; and Celaya, Carlos L., M.D., 272 Ivy Street, N.E., Atlanta 3, Georgia, "Vesical Neck Obstructions in Children," *Am. Surgeon* 27:603-607 (Aug.) 1961.

Vesical neck obstructions occur rather frequently in children. The damage to the urinary tract has often progressed to a marked degree before the condition is suspected, and the diagnosis made. Symptoms of frequency, urgency, enuresis, recurrent pyuria, low grade fever, soreness in the lower abdomen over the bladder, loss of appetite, and other gastrointestinal disturbances should suggest the possibility of urethral or vesical neck pathology. Diagnosis is made by proper urologic investigation. Treatment is by transurethral resection of the vesical neck obstruction or open operation on the vesical neck. In patients with marked upper tract damage preliminary drainage and a series of corrective operations are often needed. Patients with seriously damaged renal parenchyma have definitely reduced life expectancy, even though early results may be encouraging. A plea is therefore made for a higher incidence of suspicion of vesical neck pathology in children with recurrent urinary infections and/or symptoms of frequency, urgency, enuresis, dysuria, slow stream, straining to void, low grade fever, soreness or pain over the bladder region, lack of appetite, slow growth or unexplained gastrointestinal symptoms.

Wenger, Nanette Kass, M.D.; Watkins, W. Lorraine, M.D.; and Hurst, J. Willis, M.D., 80 Butler Street, S.E., Atlanta 3, Georgia, "A Preliminary Study of the Electrocardiogram of the Normal Premature Infant," *Am. Heart J.* 62:304-314 (Sept.) 61.

With recent advances in the diagnostic methods and in the surgical therapy for cardiac disease, cardiologists are now asked to evaluate younger and younger patients, even in the premature infant age group. We soon came to realize that normal values had not been established for the electrocardiographic deflections and intervals of the premature infant. This preliminary study was designed to determine the range of normal of the several components of the electrocardiogram of the normal premature infant, in order to enable differentiation of the pathological from the normal record.

A preliminary study was carried out on seven normal premature infants, with a total of 113 serial electrocardiograms available for analysis. Comparing our data on these normal premature infants with those for the full-term infant, some similarity was seen; however, distinct differences were equally apparent. The electrocardiogram of the normal premature infant is seen to have:

1. Greater P wave amplitude,
2. Wider range of the QRS electrical axis.
3. Smaller QRS amplitude.
4. Fewer and smaller Q waves.
5. Greater ST segment deviation.

Reese, Owen, Jr., M.D.; McLean, Ross L., M.D.; and Raagen, Tom D., M.D.; 80 Butler Street, S.E., Atlanta 3, Georgia, "Acid-Fast Bacilli in Pleural Biopsy Specimens," *Arch. Int. Med.* 108:439-441 (Sept.) 61.

Punch biopsies of the parietal pleura were obtained using the Harefield needle on a series of 15 patients with pleural effusions thought to be due to tuberculosis. Except for positive tuberculin reactions, routine work-up, including x-rays, culture of pleural fluid, sputum, or gastric washings, was not rewarding. Histologic study of these specimens revealed changes compatible with tuberculosis in eight. With appropriate staining acid-fast bacilli were seen in five of these eight. Reports of acid-fast bacilli in needle biopsy material obtained from the parietal pleura are scanty. Most authors have been satisfied that the diagnosis of tuberculosis is established when characteristic his-

tological changes are noted. We believe that the additional effort necessary to demonstrate the bacillus in these specimens, thereby establishing the diagnosis more firmly, is well worth while.

From the Department of Internal Medicine and the Department of Pathology, Emory University School of Medicine and the Medical and Pathology Services, Grady Memorial Hospital. Senior Resident in Medicine, Grady Memorial Hospital (Dr. Reese); Associate Professor, Department of Internal Medicine, Emory University School of Medicine (Dr. McLean); Assistant Professor, Department of Pathology, Emory University School of Medicine and Department of Pathology, Grady Memorial Hospital (Dr. Raaen).

Chang, C. H. (Joseph), Man Memorial Hospital, Man, W. Virginia, and Leigh, Ted F., M.D., Emory Hospital, Atlanta, Georgia, "Congenital Partial Defect of the Pericardium Associated with Herniation of the Left Atrial Appendage" Am. J. Roentgenol. 86:517-522 (Sept.) 61.

The Authors report a case of congenital partial pericardial defect associated with herniation of the left atrial appendage in a 6 year old white male and reviewed the literature pertaining to this abnormality. Congenital absence of the pericardium is a rare anomaly. In the majority of reported cases, it was found on the left side (67 per cent). The anomaly is more frequent in male than in females, the ratio being approximately 3:1.

The roentgen findings in this anomaly show certain characteristics. On the routine chest roentgenogram, an abnormal cardiac configuration is seen, there being a smooth projection from the left cardiac border just caudad to the main pulmonary artery segment. On fluoroscopic examination pulsations are noted in the mass, which appear to be paradoxical to those of the pulmon-

ary artery and aorta. The demonstration of pneumopericardium following induction of artificial pneumothorax is diagnostic. Angiocardiographic studies are helpful in determining the anatomic site of the herniation through the pericardial defect.

The pericardial defect was repaired with mediastinal pleura in this case.

Bartholomew, R. A., M.D.; Colvin, E. D., M.D.; Grimes, William H., M.D.; Fish, J. S., M.D.; Lester, William M., M.D. and Gallo-way, William H., M.D., 272 Boulevard, N.E., Atlanta 12, Georgia, "Criteria by which Toxemia of Pregnancy May Be Diagnosed from Unlabeled Formalin-Fixed Placentas," Am. J. Obst. & Gynec. 82:277-290 (Aug.) 61.

Our interest in the consistent association of certain types of placental infarcts with pre-eclampsia, eclampsia and abruptio placentae stemmed from the coincidence of an obviously fresh placental lesion associated with a case of acute pre-eclampsia.

From 1930 up to the present time, many thousand formalin-fixed placentae from both normal (controls) and toxic cases have been examined as "unknowns," enabling the establishment of reliable criteria, both gross and microscopic, by which a correct diagnosis can be made.

Up to 1950, successful diagnosis was limited to about 85 per cent. At that time it was discovered that 10 to 15 per cent of non-toxic patients develop two to four plus proteinuria and considerable hypertension during and following labor, but return to normal in 12 to 24 hours. The placentae show the typical gross and microscopic findings of toxemia. This phenomenon explained the previous deficit of complete correlation.

Space does not permit a description of the gross and microscopic appearance of the types of infarcts specific for pre-eclampsia, super-imposed toxemia, eclampsia and acute abruptio, or the mechanism of infarction.

Failure to substantiate these findings has been due chiefly to examining fresh placentae.

Biochemical investigation of placental infarcts has not revealed any product capable of reproducing toxemia. A most promising lead lies in the fact that necrosis of chorionicepithelium liberates thromboplastin which, in turn, initiates intravascular fibrination throughout the circulation, with probable capillary blockage chiefly in the liver, kidneys and brain.

Stone, H. Harlan, M.D., Grady Memorial Hospital, Atlanta, Georgia, "Cardiac Massage: A Report of 148 Cases," Am. Surgeon 27:495-501 (July) 61.

Cardiac massage was performed on 148 patients at Grady Memorial Hospital during a seven-year period. Response and survival were analyzed with respect to age, area in the hospital where arrest occurred, condition of the patient prior to arrest, predisposing factors, and status of the heart at time of thorocotomy. No patients survived cardiac arrest which occurred outside of the operating room, nor were there any survivors who were seriously ill or who had sustained recent non-operative trauma. Vagal reflexes, insufficient atropine premedication, or failure to readminister the drug, induction of anesthesia or change in method of anesthesia, post-operative over-sedation, hypovolemia, anoxia, allergic reactions, and physical stimulation of the lethargic patient were major factors. An ineffective beat with prompt response to massage had the best prognosis. No patient survived a second arrest, nor did any survive who had been in shock prior to arrest. Massage proved futile in cases of hypovolemia. Bradycardia often preceded cardiac arrest, and the use of atropine to prevent or treat bradycardia is stressed. Later cardiac deterioration, post-thorocomy infection, and risk of subsequent anesthesia are mentioned.

MEDICAL QUACKERY CONGRESS MEETS

The National Congress on Medical Quackery held in Washington, D. C. on October 6-7 has served to call attention to the cruel "profession" of those who traffic in the misfortunes of other people.

More specifically this conference has presented conclusive evidence of the need for greater law enforcement in the field of medical quackery. Whether this means more stringent laws or merely an increase in the number of people enforcing existing statutes is a question for the experts. What is glaringly apparent, however, is the fact that many people because of their unfortunate circumstances, are being victimized by confidence men who must be put out of business.

Two essential ingredients are necessary and must be present if the quack is to succeed at his trade. These

are ignorance and desperation. The con men know this and play it to the hilt. Preying on the uninformed and those who have lost hope, the quacks, charlatans and fast money boys, do their greatest harm, not by fleecing the afflicted, but by enticing their victims away from treatment by competent physicians.

Aside from the medical aspects attending the sale and use of worthless gadgets for the cure of "everything" there are economic implications involved which cannot be ignored.

The annual "take" from the sale of countless quack cures peddled by the charlatans runs in the millions of dollars. One source has estimated that a billion dollars a year is taken from the victims of quacks, and what is more discouraging is the fact that quackery appears to be on the increase rather than on the down slide.



the association

DEATHS

M. G. HENDRIX of Ball Ground, died September 18, 1961 at the age of 81. He attended the Atlanta College for Physicians and Surgeons and practiced medicine in Ball Ground until his retirement in 1936.

He represented Cherokee County in the General Assembly and was former mayor of Ball Ground. He was a charter member of the Canton Rotary Club and a former trustee of the Ball Ground school board. He was also the first president of the Citizen's Bank of Ball Ground. Dr. Hendrix was a deacon in the local Baptist Church and a Mason and Shriner. He was a member of the Medical Association of Georgia, the American Medical Association and a life member of the Cherokee-Pickens Medical Society.

His survivors include a son, Dr. Arthur M. Hendrix of Canton; two daughters, Mrs. T. M. Buchanan of Atlanta, and Mrs. Joe B. Harrison of Winder; and six grandchildren.

ENOCH CALLAWAY, JR., of LaGrange died September 27, 1961 at the age of 69. Dr. Callaway attended the University of Georgia and Tulane University where he also received his M.D. degree. He did post-graduate work at Emory University and the New York Skin and Cancer Hospital. He was resident physician at Mississippi State Charity Hospital before opening his practice in new plastic diseases.

He was director of the West Georgia Cancer Clinic and director of the Diocesan Foundation of the Episcopal Church of Atlanta. Dr. Callaway was a director and honorary chairman of the Board of Trustees of the Georgia Division of the American Cancer Society; national director of the American Cancer Society; and a member of the Southeastern Surgical Conference. He was a member of the New York Academy of Sciences; Troup County Medical Society; past president of the Fourth District Medical Society of Georgia; past president of the Medical Association of Georgia and the Georgia Chapter, American College of Physicians and Surgeons.

Dr. Callaway was a member of the Highland Country Club, Elks Lodge, Masonic order, and Sons of the American Revolution. He received the American Cancer Society Divisional Medal, Medical Association of Georgia Hardman Medal, and the American Legion Silver Life Membership.

He is survived by his wife, Jennie Crowell Callaway; a daughter, Mrs. Marc Brabant of Memphis; a son, Dr. Enoch Callaway III of San Francisco; a sister, Mrs. Harvey Nimmons of LaGrange; and four grandchildren.

CHARLES RAYMOND ARP, 48, died October 5, 1967 at his home in Atlanta. He was originally from Los Angeles and Copperhill, Tenn. Dr. Arp had been in Atlanta for almost 30 years. He attended the University of Georgia and the Medical College of Georgia and completed his medical schooling at the Medical College of Virginia. He interned at the U.S. Marine Hospital in New York and in Paris, France. Dr. Arp did postgraduate work at the George Washington University School of Medicine and with the American College of Allergists.

He served with the Georgia Public Health Department before he entered the Army where he was a captain in the U.S. Medical Corps. During his tour of duty he was awarded the Bronze Star for bravery.

Dr. Arp was a member of the Fulton County Medical Society, the American Medical Association, the Medical Association of Georgia of which he served as treasurer for several years, the American College of Allergists, the American Heart Association, the American Diabetes Association, the Southern Medical Association, and the American Therapeutic Society. He was a Diplomate of the American Board of Internal Medicine. He was an Associate in Medicine and held a teaching appointment at the Emory University School of Medicine.

He was a member of the Atlanta Athletic Club and Trinity Presbyterian Church.

His survivors include his wife, Coribel Mason Arp; a daughter, Coribel Arp; two sons, Charles R. Arp, Jr., and Phillip A. Arp, all of Atlanta.

MARSHALL R. SIMS, 78, of Atlanta died October 9, 1961. He was a graduate of the Atlanta College of Physicians and Surgeons. He interned in New York City and then returned to Atlanta where he practiced until his retirement about seven years ago.

He was a member of the Peachtree Methodist Church, the Fulton County Medical Society, and the Medical Association of Georgia.

He is survived by his wife Cornelia Stephenson Sims; two daughters, Mrs. Elwyn V. Hopkins of Atlanta and

Mrs. James E. Faw of Woodcliff Lake, N. J.; a son, Gordon B. Massengale of Baton Rouge, La.; three sisters, Miss Claude Sims of Atlanta, Mrs. Maude S. Little of Atlanta, and Mrs. Jack Sears of Clearwater, Fla.; and a brother, Harvey of Atlanta.

SAMUEL J. SINKOE of Atlanta died at the age of 69. Dr. Sinkoe attended Emory University School of Medicine and received his M.D. degree in 1913. He interned at Mt. Sinai Hospital in New York City and in the Urological Department in New York Hospital. His post-graduate work was at the University of Vienne.

Dr. Sinkoe was a member of the Fulton County Medical Society, The Medical Association of Georgia, the American Medical Association, the Southern Medical Association, and the American Urological Association. He was a member of the Ahavath Achim Synagogue, the Atlanta Jewish Community Center, the Progressive Club, and B'nai B'rith. He was a Mason and a Shriner.

He is survived by his wife Goldie Feinberg Sinkoe; a son, Joel Sinkoe of Atlanta; three sisters, Mrs. A. Klein, Mrs. Meyer Jacobstein, and Mrs. Fannie Berman all of Atlanta; and a brother, E. I. Sinkoe of Charlotte, N. C.

SOCIETIES

The CAMDEN-CHARLTON MEDICAL SOCIETY had the Glynn and Duval County Medical Societies as their guests at their October meeting.

The FLOYD COUNTY MEDICAL SOCIETY is sponsoring instructions in first aid to the Explorer Boy Scout troop there.

The GLYNN COUNTY MEDICAL SOCIETY had Dr. Wes Thomas as their guest speaker. He spoke on the diagnosis and treatment of chronic rhinitis.

The LAURENS COUNTY MEDICAL SOCIETY had Dr. Karl Sessions of the Georgia Department of Public Health speak at their annual ladies night banquet.

The SOUTHWEST GEORGIA MEDICAL SOCIETY held its regular bi-monthly meeting in Blakely. Dr. F. Dempsey Guillibeu of Albany spoke on "Hypertensive Diseases."

The SPALDING COUNTY MEDICAL SOCIETY showed movies on medical subjects at a booth at the Kiwanis Fairgrounds in Griffin during October.

The SUMTER COUNTY MEDICAL SOCIETY had as a guest speaker Dr. Joseph W. Iseman, medical director, Atlanta Regional Blood Center at a recent meeting.

The WARE COUNTY MEDICAL SOCIETY is working with their auxiliary, collecting sample medicine to send to "Care."

PERSONALS

First District

WALTER R. VOYLES of Waynesboro was recently inducted as a fellow of the American College of Surgeons at the college's clinical congress in Chicago.

FRANK T. ROBBINS has joined G. W. BARKER and R. E. STUBBS in partnership in St. Mary's as of October 1.

CURTIS G. HAMES and LOUIS H. GRIFFIN, JR. of Claxton presented papers at the recent American Heart Association's scientific session in Miami.

Second District

FRANK McKEMIE of Albany recently spoke to the Blakely Rotary Club on "Socialized Medicine."

WILLIAM VANCE WATT of Thomasville was recently inducted as a fellow of the American College of Surgeons at the college's clinical congress in Chicago.

Third District

W. G. ELLIOTT of Cuthbert was awarded a gold meritorious service medallion by the Georgia Heart Association at their meeting in September.

JOE M. WEBBER of Columbus spoke in October to the Columbus Optimist Club on "The Pathologist's Place in Medicine."

ROBERT C. PENDERGRASS of Americus was recently appointed Vice Chairman of the Section of Radiology, A.M.A.

CHARLES E. McARTHUR of Cordele was elected president of the Georgia Academy of General Practice at their annual session in October.

Fourth District

No news submitted.

Fifth District

J. WILLIS HURST of Atlanta spoke to the Medical Society of Virginia on "Recent Trends in Treatment of Coronary Arterial Disease," and was a visiting professor at the Medical College of Virginia in October.

JOHN VENABLE and BERNARD HOLLAND of Atlanta were in Europe during October visiting and studying the Mental Health Facilities.

R. BRUCE LOGUE of Atlanta spoke in October to the Florida Academy of General Practice.

FRANK L. WILSON, JR. of Atlanta recently attended the Annual Session of the American College of Surgeons in Chicago.

J. RICHARD AMERSON, IRA A. FERGUSON, JR., WILLIAM D. LOGAN, JR. and GARLAND D. PERDUE, JR. of Atlanta and ANGLIER S. WILLS of Decatur were recently inducted as fellows of the American College of Surgeons at the college's clinical congress in Chicago.

J. GORDON MARROW, R. BRUCE LOGUE, BRITT B. GAY and SPENCE S. BREWER, JR. of Atlanta presented papers during the recent scientific sessions of the American Heart Association in Miami.

Sixth District

THOMAS E. ROGERS, JR. of Macon was recently inducted as a fellow of the American College of Sur-

geons at the college's clinical congress in Chicago.

LUTHER A. TRABELL of the VA Center in Dublin, retired from VA service on October 14, 1961.

L. A. ERBELE of Macon has as an associate, Ralph E. Tarnasky, in the Macon Hospital's department of pathology.

Seventh District

FRED H. SIMIONTON of Chickamauga spent the month of October in Europe studying mental health facilities.

RAYMOND F. CORPE of Rome spoke to the 48th annual meeting of the Georgia Tuberculosis Association during October.

CHARLES R. UNDERWOOD of Marietta was recently inducted as a fellow of the American College of Surgeons at the college's clinical congress in Chicago.

Eighth District

W. O. INMAN, JR. of Brunswick has recently been appointed to the State Board of Medical Examiners.

WILLIAM H. TAILER has moved his offices from Brunswick to Darien as of October 17.

W. B. BATES of Waycross recently urged the local Lions Club to take the lead in promoting a youth physical fitness program in the community.

Ninth District

W. BEN NALLEY of Gainesville was recently inducted as a fellow in the American College of Surgeons at the college's clinical congress in Chicago.

A. FREDERICK BLOODWORTH of Gainesville was installed as president of the Georgia Thoracic Society at the annual joint meeting of the Society and the Georgia TB Association in October.

HENRY S. JENNINGS, JR. of Gainesville was chosen as "Scouter of the Week" in October.

GEORGE T. NICHOLSON announced recently the association of George G. Grant III in the practice of medicine and surgery in Cornelia.

THE NINTH DISTRICT MEDICAL SOCIETY met recently in Lawrenceville with the Chattahoochee Medical Society as host.

Tenth District

RICHARD S. OWINGS, PRESTON ELLINGTON, and ALFRED J. GREEN of Augusta were elected Fellows of the American Academy of Pediatrics recently.

CORBITT H. THIGPEN of Augusta was guest speaker at the luncheon meeting of the Kiwanis Club of Uptown Augusta in October.

ROBERT B. GREENBLATT of Augusta recently delivered a number of scientific papers during a two week tour in South America. He visited Peru and Columbia.

WILLIAM T. LUCAS of Augusta spoke to the Richmond County Medical Assistants in October.

HOKE WAMMOCK of Augusta spoke to the Chatham County unit of the American Cancer Society at the Hellenic Center in Savannah recently.

An experimental drug, being tested by ROBERT B. GREENBLATT, WILLIAM E. BARFIELD, and EDWIN C. JUNGCK, has been found to induce ovulation.

ARTHUR B. CHANDLER of Augusta presented a paper during the recent scientific session of the American Heart Association in Miami.

HAROLD E. ENGLER of Augusta was recently inducted as a fellow of the American College of Surgeons at the college's clinical congress in Chicago.

CALLED EXECUTIVE COMMITTEE OF COUNCIL MEETING PHONE CALL CONFERENCE

SECRETARY MAULDIN called the phone call conference meeting of the Executive Committee of the Council of the Medical Association of Georgia to order at 4:00 P.M. on September 21, 1961.

Members of Executive Committee of Council present included Fred Simonton, Chickamauga, President; Thomas Goodwin, Augusta, President-Elect; Milford B. Hatcher, Macon, immediate Past President; John T. Mauldin, Atlanta, Secretary; Linton Bishop, Atlanta, First Vice President; and J. G. McDaniel, Atlanta, Finance Chairman.

Also present were Messrs. Milton D. Krueger and James M. Moffett of the Headquarters Office Staff, Atlanta.

Kerr-Mills Implementation

Secretary Mauldin reviewed the September 20, 1961 meeting of the Council on Hospital Licensure, Construction, and Indigent Care. Dr. Mauldin had been requested to attend this meeting in the place of the Association's three representatives. Discussion ensued about the arrangement between the Welfare Department and the Health Department in implementing the Kerr-Mills law. It was stated that as yet no definite contractual relationship had been agreed upon by the Welfare Department and Health Department. There was discussion further as to the Association's interest in this program in view of the problems connected with the proposed contractual relationship between the Welfare and Health Departments.

On motion duly made and seconded it was voted that if there is need, the Medical Association of Georgia is receptive to discussing the matter further with the Welfare Department to investigate fully to get all the facts for further study and evaluation on the Medical Assistance to the Aged program in the interest of the health care of the aged.

There being no further business, the meeting was adjourned at 4:25 P.M.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

A special meeting of the Executive Committee of Council was called to order by Chairman of Council George H. Alexander at 9:50 A.M., October 8, 1961, at MAG Headquarters Building in the absence of the President.

Those present at the meeting were: George H. Alexander, Forsyth, Chairman of Council; Milford B. Hatcher, Macon, Immediate Past President; Thomas W. Goodwin, Augusta, Presi-

dent-Elect; John T. Mauldin, Atlanta, Secretary; J. G. McDaniel, Atlanta, Chairman of Finance; George Dillinger, Thomasville, Councillor; Mr. John Moore, MAG Attorney; Mr. Milton D. Krueger, Executive Secretary, and Mr. James M. Moffett, Assistant Executive Secretary.

The Executive Committee met to appoint an Acting Treasurer of the Association due to the death of C. Raymond Arp, Treasurer, on October 5, 1961. On motion (Hatcher-Mauldin) the Committee voted to appoint J. G. McDaniel as temporary, Acting Treasurer of the Association, due to the death of the Association Treasurer C. Raymond Arp. Dr. McDaniel will serve until such time as Executive Committee appoints a successor to Dr. Arp.

There being no further business the Executive Committee meeting was adjourned at 9:58 A.M.

Another Executive Committee meeting was called to order at 1:45 P.M. on October 8, 1961, at MAG Headquarters by George H. Alexander, Chairman of Council.

Those attending this meeting were Acting President Linton H. Bishop, Atlanta; George H. Alexander, Forsyth, Chairman of Council; John T. Mauldin, Atlanta, Secretary; J. G. McDaniel, Atlanta, Chairman of Finance; Milford B. Hatcher, Macon, Immediate Past President; Thomas W. Goodwin, Augusta, President-Elect; Mr. John Moore, MAG Attorney, Mr. Milton D. Krueger, Executive Secretary; Mr. James M. Moffett, Assistant Executive Secretary, and Catherine Wooten, Executive Assistant.

The purpose of this meeting was to designate a Medical Director for the Medical Assistance to the Aged Implementation program. After general discussion it was suggested that Dr. Mauldin be designated as the Medical Director. On motion (Goodwin-Hatcher) it was voted that John T. Mauldin be designated as the Medical Director of the Medical Assistance to the Aged Implementation program at a salary to be determined by Executive Committee at a later date.

There being no further business the meeting was adjourned at 2:00 P.M.

MEDICAL ASSOCIATION OF GEORGIA COUNCIL MEETING

THE SPECIAL CALLED MEETING of the Council of the Medical Association of Georgia was called to order by Chairman George H. Alexander at 10:10 A.M., October 8, 1961, at MAG Headquarters, Atlanta.

The invocation was given by Dr. Milford B. Hatcher.

Those attending the meeting were: George H. Alexander, Forsyth, Chairman of Council; Linton H. Bishop, Atlanta, 1st Vice President; Thomas W. Goodwin, Augusta, President-Elect; John T. Mauldin, Atlanta, Secretary; Milford B. Hatcher, Macon, Immediate Past President; J. Frank Walker, Atlanta, Speaker of the House, Charles E. Bohler, Brooklet, 1st District; George Dillinger, Thomasville, 2nd District; Frank Wilson, Leslie, 3rd District; Virgil Williams, Griffin, 4th District; Floyd Sanders, Decatur, 5th District; William Rawlings, Sandersville, 6th District; Ralph W. Fowler, Marietta, 7th District; C. R. Andrews, Canton, and P. T. Scoggins, Commerce, 9th District; J. G. McDaniel, Atlanta, and Charles S. Jones, Atlanta, Fulton County Medical Society; E. A. Allen, Atlanta, J. W. Chambers, LaGrange, and Henry H. Tift, Macon, AMA Delegates; and Edgar Woody, Jr., Atlanta, Editor, JMAG. Also attending were Mr. John Moore, MAG Attorney, Mr. Alan Kemper, Mr. Harold Parker, Mr. Phil Cawthon and Mr. Charles Doolittle, all of the State Department of Public Welfare; Mr. Milton D. Krueger, Executive Secretary; and Mrs. Catherine Wooten, Executive Assistant.

The Special Called Meeting was recessed at the request of Chairman Alexander and another special called meeting was called to confirm the action of the Executive Committee on the Appointment of an Association Treasurer. Mr. Moffett read the motion made at the Special Executive Committee meeting prior to this special Council meeting: "On motion (Hatcher-Mauldin) the Committee voted to appoint J. G. McDaniel as temporary Acting Treasurer of the Association, due to the death of Association Treasurer C. Raymond Arp, and will serve until such time as the Executive Committee appoints a successor to Dr. Arp." On motion (Hatcher-Mauldin) Council voted to confirm the action of Executive Committee and appoint Dr. McDaniel Acting Treasurer of the Association, due to the death

of Association Treasurer C. Raymond Arp, with the understanding that he will serve until such time as the Executive Committee appoints a successor to Dr. Arp.

Chairman Alexander then appointed a committee to draw up a Resolution on the death of Dr. Arp and to nominate a successor. He appointed J. G. McDaniel, Chairman, John T. Mauldin and Linton H. Bishop as members of this committee.

The meeting was adjourned at 10:15 A.M.

The regularly scheduled Special Called Meeting of Council was then called to order.

The minutes of the Called Executive Committee of Council Phone Call Conference Meeting of September 21, 1961 were read by Mr. Krueger. At the suggestion of Dr. McDaniel the minutes were corrected as follows: "At the request of the President this Special Meeting of Executive Committee of Council was called." The minutes were then corrected as above and on motion duly made and seconded were approved as read.

PROPOSED REVISION OF MAG CHARTER—Dr. Bishop gave background information regarding the wording of the Charter. The rewording of the Charter by the MAG Attorney was read and on motion (Mauldin-Hatcher) it was voted to adopt this Resolution, as follows:

CERTIFICATE

GEORGIA

FULTON COUNTY

I, JOHN T. MAULDIN, M.D., do hereby certify that I am Secretary of THE MEDICAL ASSOCIATION OF GEORGIA, and further certify that the following is a true and correct copy of a Resolution unanimously adopted by the Council of the Medical Association of Georgia at a special meeting thereof held at Atlanta, Georgia, on the 8th day of October, 1961, at which a quorum was present:

"BE IT RESOLVED, that the charter of THE MEDICAL ASSOCIATION OF GEORGIA be amended so as to provide that it is exclusively and purely a charitable, educational and eleemosynary corporation to advance the science of medicine, promote good health and provide better medical care for the general public as a general public charity.

"BE IT FURTHER RESOLVED, that Paragraph 2 of the original charter granted June 10, 1901, as heretofore amended, be stricken and a new Paragraph 2 be substituted in lieu thereof to read as follows:

'2. The objects, purposes and powers of the corporation are:
'—to engage exclusively and solely in charitable, educational and eleemosynary activities related to the science of medicine for the benefit of the general public;
'—to advance and promote the science and study of medicine in the interest of all mankind;
'—to advance and promote the study and use of the allied sciences in the interest of all mankind;
'—to establish and maintain medical libraries for the use and benefit of physicians and the general public;
'—to hold such property, real and personal, as it may have or acquire solely for the benefit of the general public;
'—to use any incidental income it may receive exclusively for charitable, educational and eleemosynary activities related to the science of medicine for the benefit of the general public;
'—to make its facilities and properties available for research and dissemination of medical knowledge;
'—to operate its facilities and properties as a general public charity and to make them available to the general public as well as physicians and scientists for holding scientific programs and meetings of all kinds relating to medicine, health and/or health practices tending in any wise to promote the science of medicine, alleviate disease and illness, or advance the standards of health;
'—to discipline its members, uphold the ethics of the profession, and maintain high standards of practice of the science of medicine so that the highest professional service may be rendered in the interest of all mankind; and
'—generally to do and perform all things consistent with the foregoing objects, purposes and powers which tend in any wise to advance the science of medicine, promote good health, and provide better medical care for members of the general public.'

"BE IT FURTHER RESOLVED, that the officers be authorized and directed to take whatever steps may be necessary

to obtain said amendment of the charter of the corporation."

Background Data On Kerr-Mills Implementation

Secretary Mauldin gave information on the progress to date of the Kerr-Mills Implementation program. There was general discussion afterward.

AMA Board of Trustees Report

Dr. Allen, AMA Delegate, reported on the last AMA Board of Trustees meeting. This report was received as information.

Chairman Alexander recessed the Council meeting for luncheon at 12:05 p.m.

The Council meeting was reconvened at 1:00 p.m. and proceeded with the business at hand.

Proposed Welfare Department Plan and MAG Contractual Relationship

Chairman Alexander introduced the members present representing the State Department of Public Welfare and asked Judge Kemper to speak to the Council members. He made a few remarks about the Hospital Care for Old Age Assistance Recipients program and asked for questions from Council. MAG Attorney John Moore read the proposed contract between the Georgia State Department of Public Welfare and the Medical Association of Georgia and Council members asked questions of the State Department of Public Welfare members. Dr. Hatcher recommended that if, under the provisions of Paragraph 1 of the MAG-Welfare Contract, the Welfare Department consulted other parties or agencies for advice, that the Welfare Department would so notify the Association. After Dr. Hatcher's recommendation, Judge Kemper verbally agreed to notify the Association if another agency is consulted for any reason on medical aspects. The question and answer period was then concluded and Chairman Alexander thanked

Judge Kemper and his staff for attending the meeting and they departed.

MAG Council Consideration and Action on Proposals

Chairman Alexander asked for discussion of any phase of the contract which was not clear. Dr. Hatcher's recommendation was approved and this change was to be made in the wording by the MAG Attorney. On motion (Hatcher-McDaniel) the following resolution was unanimously adopted:

RESOLVED, that Council of the Medical Association of Georgia approves the contract with the State Department of Public Welfare, attached to these minutes and made a part thereof, in principle, and authorizes and directs the Officers of this Association to execute and attest said contract on its behalf, and to agree to and make any further changes in wording as may be required in said Contract;

RESOLVED, FURTHER that the execution of a Contract with the State Department of Public Welfare by the President or First Vice President of the Association, and attested by its Secretary, shall be conclusive evidence of this Council's approval of the terms of said Contract.

On motion (Dillinger-Hatcher) it was voted that the administration of the program be delegated to the Executive Committee for implementation. The appointment of a Medical Director was discussed and referred to Executive Committee for decision.

Chairman Alexander asked for a recess of the Council meeting to allow the Executive Committee to meet to appoint a Medical Director as it was urgent that he be named at once.

Council recessed at 1:45 p.m.

Chairman Alexander reconvened the Council meeting at 2:00 p.m. The motion recorded in the Executive Committee meeting minutes was read as follows: "On motion (Goodwin-Hatcher) it was voted that John T. Mauldin be designated as the Medical Director of the Medical Assistance to the Aged Implementation program at a salary to be determined by Executive Committee at a later date." On motion duly made and seconded the action of the Executive Committee in designating John T. Mauldin as Medical Director was approved.

There being no further business the meeting was adjourned at 2:05 p.m.

NEW FILM EXPLAINS O.A.S.I. DISABILITY PROGRAM

The Social Security Disability Program has been in operation a little over six years in Georgia, and the success of the Program has been, to a great extent, due to the co-operation of the medical profession.

The treating physician has been called upon many times for additional information, in addition to the original form he has completed for a patient. Also, many of the patients have been asked to go for examinations by specialists, even though information has been submitted by the treating physician. Even after extensive medical workup, many claims are denied.

In order for the physician to better understand the OASI Disability Program, the Bureau of Old-Age and Survivors Insurance, in co-operating with the American Medical Association, has produced a film entitled "The Disability Decision." This film is designed especially for

the medical profession with particular emphasis on the type information needed from the doctor. (This, many times, will eliminate additional requests for information).

"The Disability Decision" has been shown to eleven local medical association groups in Georgia, and there have been many favorable comments from those who have seen it. The film is available to any medical group at any time. Also, representatives who administer the Disability Program in Georgia will be glad to show the film and try to answer any questions regarding the administration of the Program.

If any group would like to make this a part of your future program, arrangements may be made by contacting your local Social Security or Vocational Rehabilitation representative.

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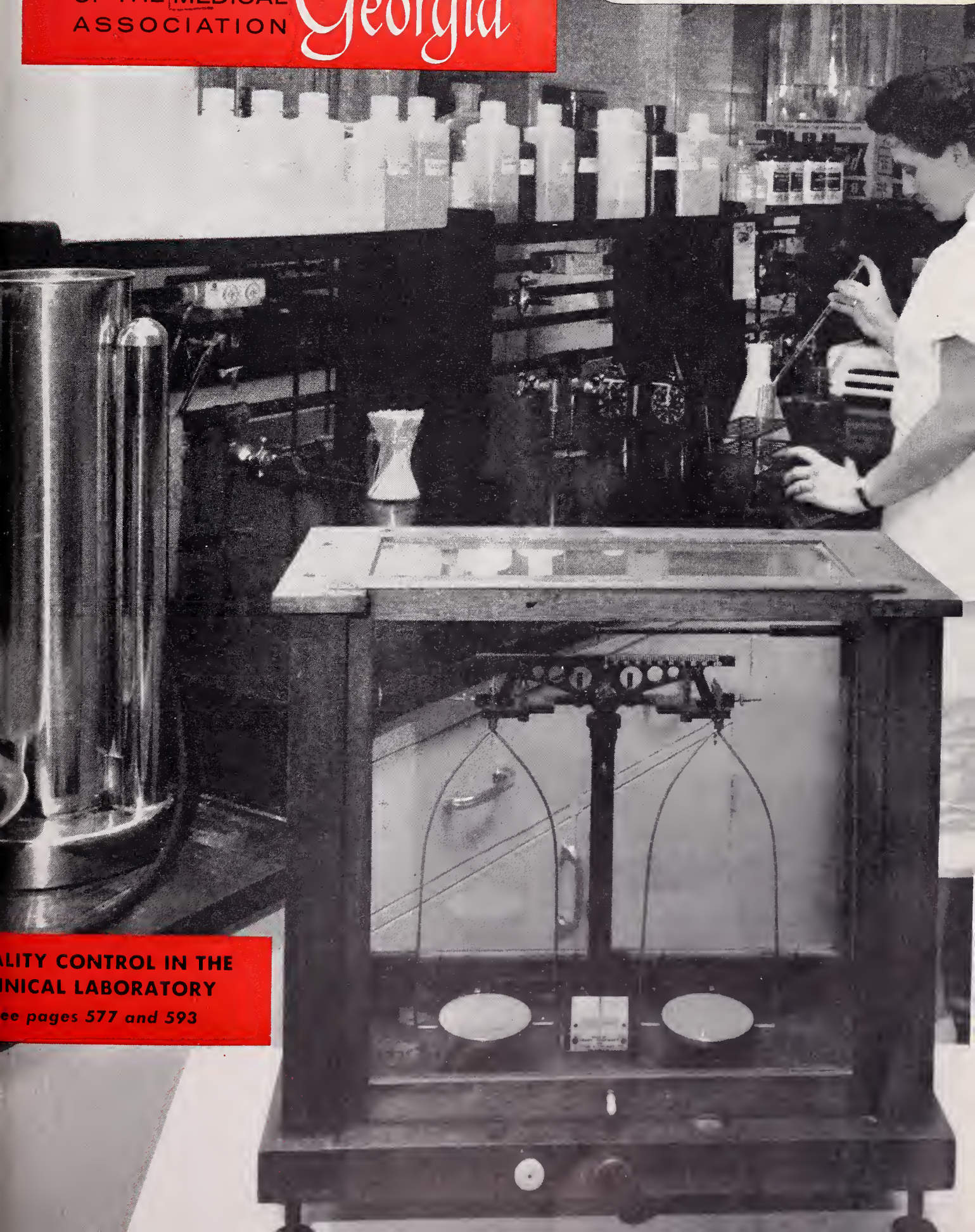
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PERFUSION IN MALIGNANCY

Edgar D. Grady, M.D., Luther Rollins, M.D. and Walter Sale, M.D., *Atlanta*

- ***This method offers promise of help for the otherwise hopeless cancer patient, who still has his disease localized to a region of the body where the arterial circulation can be approached separately.***

ALL PERFUSION METHODS of treating cancer are based on the aim of concentrating an anti-cancer agent in the area of a cancer. The agents are introduced into the circulation supplying the cancer in order to get more effect there than in the rest of the body. These methods offer in our hands an opportunity for giving objective and subjective improvement with return of comfort and activity in certain otherwise untreatable advanced cancer patients.

There are three different methods of treatment based on this principle, which the authors are currently using and will present:

1. Constant slow intra-arterial infusion with an anti-cancer chemical, and simultaneous intra-muscular administration of its antidotes.

2. Isolation perfusion with anti-cancer chemicals.

3. Intra-arterial injections of large particle isotopes.

Intra-arterial administration of an anti-cancer drug was first utilized with some successful palliation by Klopp,¹ when he gave intermittent injections of nitrogen mustard via arterial catheters. His principle approach was to treat advanced cancer of the head and neck with doses of nitrogen mustard given in varying small doses intermittently throughout the day for several days to maximum tissue tolerance. One of us^{2,3} has used this method to treat a number of different types of lesions both in the head and neck and in the pelvis. Stephens⁴ has reported a similar use of intra aortic nitrogen mustard with considerable palliation. Likewise,

Byron⁵ has used intra-aortic nitrogen mustard to treat advanced pelvic disease.

Sullivan⁶ introduced the concept of slow constant infusion of an anti-cancer drug intra-arterially into a cancer region while peripherally this drug's antidote was given intra-muscularly. He found that ten times the usual lethal dose of amethopteryn (an anti-folic acid agent) could be given in a slow intra-arterial infusion if folinic acid (the third metabolic

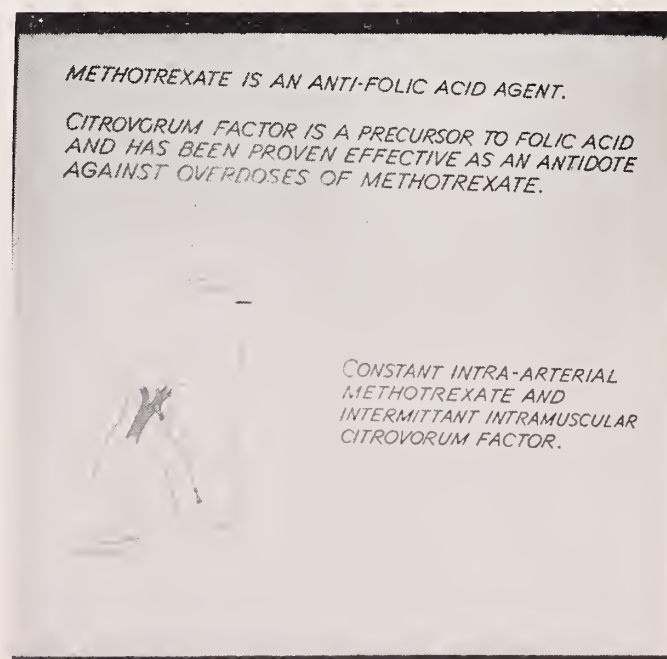


Figure 1. Anti-metabolite Metabolite Therapy.

product of folic acid) was given intermittently in a distant muscle. In this way the cancer cell receives a high concentration of amethopteryn, while at the bone marrow and G.I. tract sufficient folinic acid is

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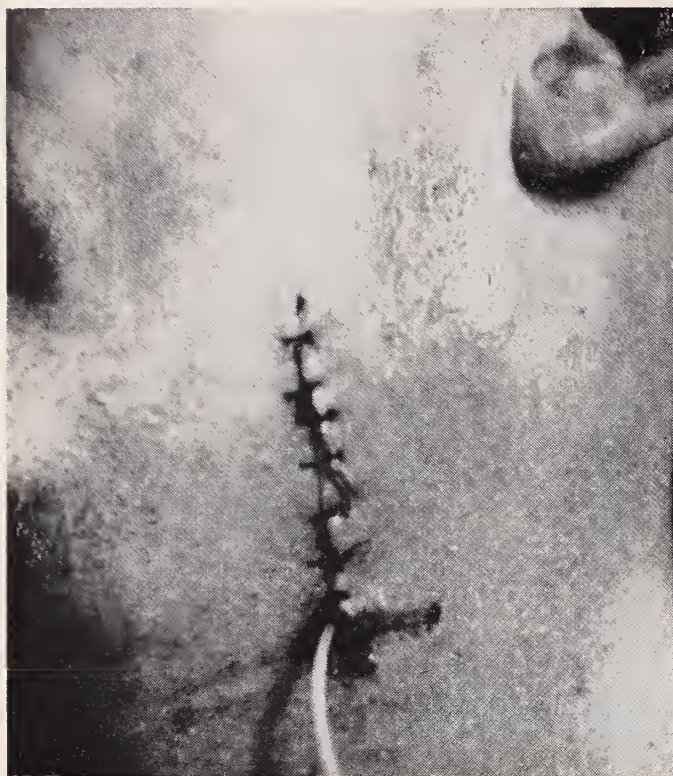


Figure 2. A catheter has been placed securely in the external carotid artery for constant infusion with Methotrexate (amethopteryn). Infusion may last one to three weeks.

present to maintain the normal metabolic pattern. Sullivan reported 43 patients with head and neck cancer six with cancer of the cervix and two with malignancy in the bladder treated by this method. Thirty-one of these showed a partial regression of tumor and six showed apparent total regression. At the same time, he described numerous complications resulting from the faulty placement of catheters hemorrhage and normal tissue necrosis from the drug.

The authors of this report have used the same technique in four patients. There was temporary partial regression of tumor in two patients. A third died from cerebral vascular insufficiency when the internal carotid received a portion of the drug. The fourth patient with pharyngeal cancer apparently had all of his disease eradicated but had enough slough of normal tissue to produce erosion of a major vessel and exsanguination therefrom. The usual dose given was 25 mgm. of amethopteryn into each external carotid artery for head and neck or the same into each internal iliac artery for pelvic disease. At the same time, 6 mgm. of folinic acid (citravorum factor) was given intra-muscularly every four hours. The bone marrow and G.I. tract in every case were well protected.

The next variant of this system of treating cancer is that of isolating the circulation to a cancer area and perfusing this area with a high concentration

of an anti-cancer drug. With an artificial heart-lung (pump and oxygenator) circulating a segment of the body in isolation, a high concentration of a needed drug can be passed through a cancer without damaging the rest of the body with the drug's toxic effects. This has been proved by Creech⁷ and others^{8,9} to be reasonably effective in treating melanoma and sarcoma of an extremity. The circulation of an extremity can be effectively isolated with very little

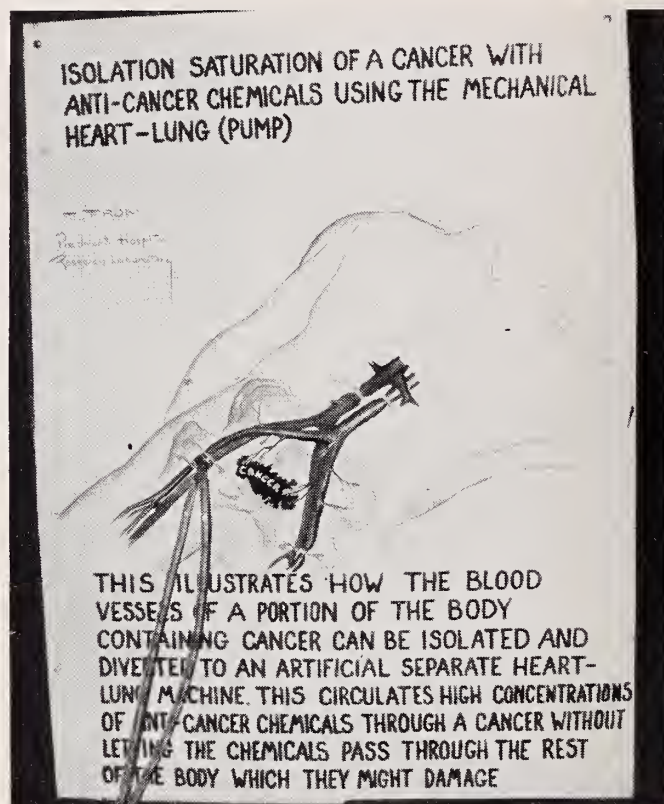


Figure 3. Illustration of how the circulation of a pelvic cancer may be isolated and connected to an artificial heart and lung for perfusion with appropriate drugs.

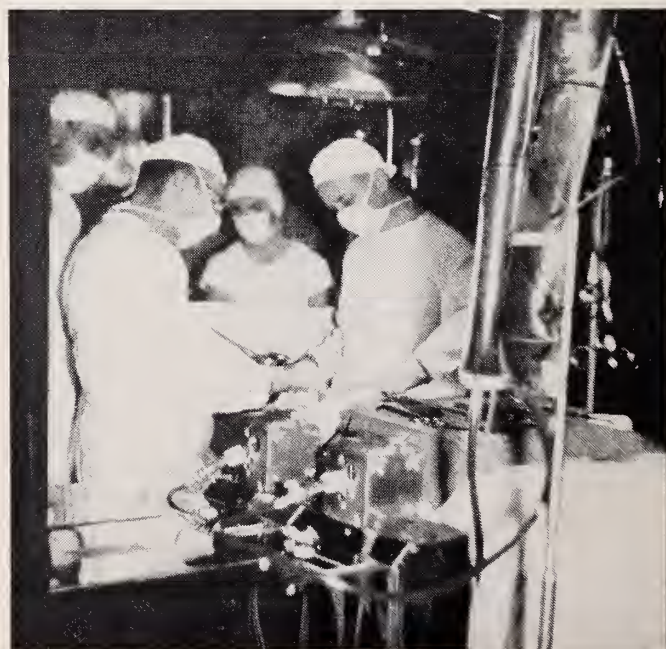


Figure 4. In the operating room the pumps and oxygenator are connected to the catheters in the isolated blood vessels.

spill to the general circulation. The pelvis can be isolated so that the collateral small vessels, which one cannot clamp or ligate, will spill into the general circulation only about one per cent per minute. This means that when isolation of pelvic circulation is attempted, there is still an average mixing of about 30 per cent in one-half hour with the general circulation. In spite of numerous innovations and attempts at isolating lung, liver, entire abdominal viscera, breast, head and neck, there has generally been found too much mixing with the general circulation in these areas, for practical application to date.

Because of the mixing of the attempted isolated circulation and the general circulation, drugs must be selected of short chemical life, or else they should be thoroughly washed out before returning the isolated circulation back to the rest of the body. For example, nitrogen mustard has a chemical life in vivo of only about eight minutes, and therefore, if 10 mgm. were injected every ten minutes for three or four doses into an isolated segment of the circulation, this agent would have spent its effectiveness in a forty minute perfusion. There would be no danger of turning such a segment of blood back into the general circulation. Drugs with a chemical life of several hours like phenylalanine mustard (sarcolysin) would have to be irrigated from an isolated circulation segment, before mixing this segment back with the general circulation.

Experience With Isolation Perfusion

Again, the authors of this report report have used this isolation perfusion on five cases with advanced pelvic cancer and one case with otherwise untreatable melanoma of an extremity. They are briefly described.

1. A pelvis filled with residual squamous cell carcinoma recurrent after radiation, was perfused with 40 mg/kg of five Fluorouracil for 45 minutes. The pelvic mass decreased by 50 per cent of pre-perfusion size, and pain was greatly decreased. Palliation was for about three months, and death of patient occurred six months after isolation perfusion.

2. Another pelvis with post-operative, post-systemic chemotherapy and post-irradiation recurrent papillary cyst adeno carcinoma of the ovary was treated with 98 mg. of Dihydro E-73,* and 20 mg. of nitrogen mustard for fifty minutes. This mass decreased to one-fourth its pre-therapy size and patient received tremendous palliation with return to full activities. Disease then progressed to near fatal state for patient, but it was again controlled by systemic

chemotherapy using three drugs simultaneously (five Fluorouracil, cytoxan and methotrexate.) Again, in three months disease began to increase and this patient has recently received intra-arterial large particle isotopes injection. (See report below).

3. A lower extremity covered with and infiltrated throughout with melanoma was perfused with phenylalanine mustard for 40 minutes. This patient had a renal shutdown post-perfusion and died a week post operatively. Metastases were found in the other groin.

4. This post irradiation recurrent squamous cell carcinoma of the cervix with frozen inoperable pelvis was treated by isolation perfusion for 50 minutes with 98 mgm. of Dihydro E-73 and 20 mgm. of nitrogen mustard. There was no complication to the therapy. There was a decrease in the pain and cleaning up of the sloughing of the vaginal lesion with some slight reduction in size of pelvis mass; however, there has been apparently little reduction in the progress and severity of this patient's disease.

5. This post radical hysterectomy with recurrent inoperable carcinoma of the cervix, treated again by cobalt therapy and still recurring with frozen pelvis had pre-perfusion a sloughing incapacitating bleeding and painful pelvis and vaginal necrotic cancer mass. She received 98 mgm. Dihydro E-73 and 20 mgm. of nitrogen mustard by pelvic perfusion for 50 minutes. There was no post perfusion complication, and she had immediate pain relief. There was a gradual cleaning up of the slough in the vagina with an immediate cessation of vaginal bleeding. The pelvic mass decreased by 50 per cent, but two months after perfusion, vaginal bleeding began to recur and a vesico vaginal fistula developed. Thereafter, the patient was given systemic chemotherapy of three drugs (cytoxan, five Fluorouracil, and methotrexate) and anabolic hormone support. Again she had cessation of bleeding and cleaning up of slough in vagina and bladder. The tumor mass has decreased a small amount during the last phases of treatment. She is comfortable, takes urinary antiseptics and is active with only a small amount of pain controlled by mild analgesics. She is being maintained on her systemic chemotherapy.

6. A male patient with massive squamous cell carcinoma of the entire pelvis area, arising in the bladder, had refused any transplant of ureters of exenteration procedure and was therefore treated by pelvic perfusion. One ureter was completely blocked off and the other only partly prior to the perfusion. For 50 minutes circulation was isolated and he received 98 mgm. Dihydro E-73 and 20 mgm. nitrogen mustard in his isolated pelvis circulation. In the early post perfusion phase, he developed anuria and

* This is a soil sample antibiotic drug derivative. When given systemically, it produces no bone marrow depression, but causes intolerable nausea and vomiting. Theoretically, it should be an ideal anti-cancer drug to use in an isolated circulation segment.

PERFUSION IN MALIGNANCY / Continued

shock. This patient died three days after perfusion without benefit.

A third method of concentrating the agent of treatment into the arterial circulation of a tumor mass has been developed by the authors of this report, using relatively large particles of radioactive isotopes administered intra-arterially. Such a particle had been previously developed in England by Cook and Pochin^{10,11} for intra-venous administration to treat lung cancer. Dr. Clyde Orr of the Experimental Engineering Station of Georgia Institute of Technology modified this original production to make a particle of Yttrium (90) slightly larger than the ordinary capillary. These isotopes have a half life of 2.54 days, and are radioactive with beta rays only. They will penetrate normal tissue only a few millimeters. The size of the particles made ranged from 50 to 100 microns in largest dimension, so that they can not pass through an ordinary capillary. Sufficient animal work¹² was done injecting suspensions of these radioactive particles into the arteries of normal organs to prove: that the majority of the particles are trapped in such an organ; that no

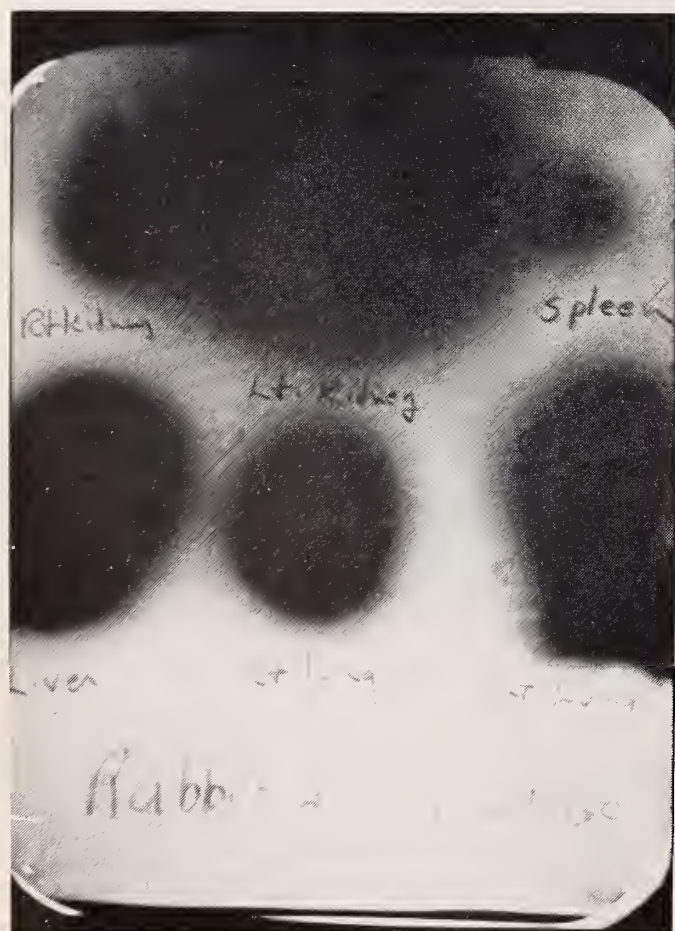


Figure 5. Autoradiographs of tissues from an animal in which 10 millicuries of Y (90) particles 50 to 100 microns were injected into the left renal artery. Counts and the radiographs indicated that 70 per cent of the particles were trapped in the left kidney.

mechanical damage occurs from the micro emboli; spillover to the brain was also harmless; and the radiation effect was comparable to external radiation. This method of radiation offers the following advantages:

1. Administration is done in a single dose.
2. The effect of the radiation is practically all in the area of the disease.
3. There should be little systemic reaction.
4. The overlying skin and other soft tissue would receive less radiation and therefore less damage.
5. The use of beta emitting isotopes is extremely safe for those using the isotope and for those attending the patient, because of its shallow penetration of tissue.

It is hoped that the further trial will prove that it is safe to give much larger amounts of radiation than has been possible with conventional types of

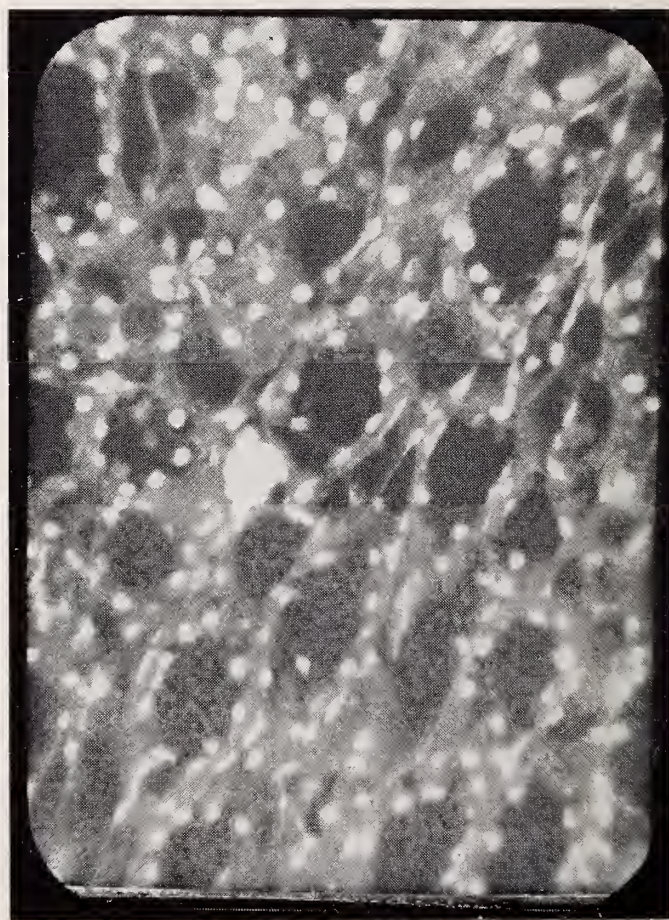


Figure 6. Microscopic section of a kidney from a rabbit in which Y (90) particles had been injected into the renal artery of that kidney. Note the single large white irregular particle and the lack of surrounding tissue damage.

therapy because of the homogeneous distribution throughout the disease and because of the lack of damage to the overlying soft tissue and of the lack of systemic reaction. The two patients treated by this method (although very recently) bear out the above contentions. Brief preliminary reports are included. Details of followup will be described later.

1. (This is the same patient described in Case two of isolation perfusion above). Because of a recurrent mass of cancer in the left pelvis only (demonstrated by exploratory laparotomy as ovarian papillary cystadenocarcinoma), this patient was treated by intra-arterial administration of large particles of Y (90). A left femoral arteriotomy was done and a #6 ureteral catheter was passed up into the left common iliac artery. Position was verified by x-ray after injecting 10 cc of 50 per cent hypaque. A pneumatic arterial tourniquet was placed around the left upper thigh, inflated and held for 15 minutes after injection of 100 mgms. of Y (90) which had a radiation value of 165 millicuries. The mass of tumor tissue had been estimated so that the dose was approximately 20,000 rads.

The patient had absolutely no symptom attributed to radiation reaction. There was no vestige of radiation reaction in the skin, vagina or rectum. Counts with probe of survey meter held immediately against the skin or vaginal mucosa showed that for all practical purposes the radiation was concentrated in the left pelvic area where the tumor was. There was a trace of radiation found in the peripheral blood. The urine and feces likewise carried a trace of radioactivity. Three weeks after the administration of the isotopes, all vestiges of radioactivity were gone, it having tapered gradually during that time. Twenty-six days after administration, the tumor mass was 50 per cent of its pre-irradiation size and the patient was normally active in every way.

2. A 48 year old white male who had eight years previously had his left eye enucleated for a melanoma, was found at laparotomy to have extensive involvement of his liver by metastatic melanoma. Two weeks later he received 34 millicuries of Y (90) in 300 mgm. of particles injected as a suspension in a catheter placed in the ostium of the celiac artery. A radiopaque plastic catheter with bent tip had been located there by fluoroscopy and arteriography. A great percentage of the isotopes apparently went into the celiac artery, but a portion apparently spilled down the aorta into the next branches. Counts in the ensuing five days showed that practically all the radioactivity had been localized generally throughout the abdomen. (There was almost none in the lower extremities). Again, the peripheral blood, urine and feces showed traces of radioactivity. In this patient, again there was no sign of radiation sickness, no skin reaction, and the patient has suffered no sequella from the radiation. After four weeks, there was demonstrable decrease in liver size. Increased appetite, eight pounds weight gain, pronounced subjective improvement and a better mental outlook followed the treatment.

Conclusions

Three methods of perfusing a segment of a patient's body containing advanced cancer have been described: (1) Intra-arterial infusion of a chemical intermittently and constantly, (2) Isolation perfusion with anti-cancer drugs and (3) Intra-arterial administration of large particle isotopes. The use of perfusion with anti-cancer chemicals offers palliation and control of disease in certain selected cases. In the present author's experience, use of three different anti-cancer chemicals simultaneously may offer additional useful palliation. The use of intra arterial large particle isotopes is apparently not hazardous, and offers an additional effective way of getting irradiation into cancer.

Addendum: 11-5-61

Additional report on the use of large particle Y-90 intra-arterially

Case number one immediately above, 5½ months after treatment, now has no evidence of disease. She has resumed all of her normal activities and is leading a full and completely comfortable life.

Case number two above received some decrease in the size of the liver, but disease is again progressing.

A third case of bile duct carcinoma with a huge liver, jaundiced and very large general abdominal masses was treated on 5-7-61 with intra-aortic injection of 200 millicuries in the area of the celiac artery while the aorta was occluded just inferiorly by a distended balloon, and by 100 millicuries in the terminal aorta with tourniquets on the thighs. She received considerable reduction in size of liver, and reduction in jaundice. Jaundice, however, later increased due to residual tumor obstruction of the ducts. On 11-1-61 laparotomy was done in the face of considerable liver damage. Large cystic ovaries 20 cm across were removed, the bulk of the liver was now found free of cancer but cirrhotic from biliary obstruction, and the patient died post operatively from uncontrolled bleeding in the abdomen. The ovaries and liver biopsy all showed no active tumor cells. An additional 350 millicuries of Y-90 were injected intra-aortically with tourniquets on the thighs, but this obviously had no bearing on the patient's death.

On 10-31-61 a patient with large residual and progressive transitional cell cancer of the bladder (after partial cystectomy) received 350 millicuries of Y-90 large particles in his terminal aorta while tourniquets were in place on the thighs. He has had no toxicity: no radiation sickness and no drop in blood count. At the present time (five days later) his tumor masses have decreased by over 50 per cent, pain is greatly decreased and the patient feels stronger. Radiation measured by a survey meter has

PERFUSION IN MALIGNANCY / Continued

been perfectly concentrated in the area of his disease.

Another patient with recurrent pelvic cancer after an abdomino-perineal resection was treated the same way on the same day. This patient had a small amount of anticancer drugs systemically for only three days on the 10th, 9th and 8th pre-isotopes injection days, because of impossible pain. Some pain relief was accomplished and no drug toxicity was present until the day after the isotopes administration. At that time, she developed severe bone marrow depression and ulceration of mouth. (Obviously the drugs should have been withheld or a smaller dose given.) The patient's disease has on the 5th post-isotope day greatly reduced — a large perineal implant has vanished. She seems to be recovering from her drug toxicity and may end as a good result.

Finally on 10-31-61, a patient with her abdomen half filled with cancer in her liver, originating in the gall bladder, was given 400 millicuries of Y-90 particles in her aorta above an occluding balloon placed just below the celiac artery. The radiation has been measured to be fairly well concentrated in the area of her tumor, though not quite as well as was found in the pelvic cases. This patient has had no toxic effects, she has improved subjectively, but the tumor has not yet noticeably regressed. Judging by the other liver cancer we have treated, regression will probably occur later.

The following additional animal work has been done:

Five dogs have had up to 18.75 millicuries of large particle Y-90 injected into an internal carotid artery in June, 1961. There was only 15 per cent retention in the brain, but 100 per cent of retained material was localized to the side injected. No damage was apparent to the brain, as demonstrated by histological studies, electro encephalograms and clinical observation. One dog is still being kept under observation and is in good health. The others were sacrificed for autoradiographs, direct radiation counts and histologic study.

A larger particle, from 100 to 150 microns, has been prepared by Georgia Tech for us to use in other animals in order to attempt localization in the brain. Perhaps brain tumors will be amenable to this method of treatment.

Increasing doses of the original size (50-100 microns) were given intravenously to five other dogs. As much as eight millicuries per kilogram were

tolerated, with about 65 per cent being localized in the lungs. Help should certainly be possible for lung cancers. Administration will be done intravenously for bilateral lung tumors or by catheter placed through the right heart into the appropriate pulmonary artery, when the disease is localized to one side.

Treatment of otherwise hopeless cases is all that is planned in patients for the present. However, it is conceivable that this method may play a part later as a pre-operative addition to shrink large cancers and assure their operability.

More detailed reports on the above work will follow elsewhere. Credit is given to Dr. Robert Mabon of Atlanta for helping with the work on the dogs' brains. Mr. Albert Drolet of St. Joseph's Infirmary has generously done the electro encephalographs. Dr. Clyde Orr of Georgia Tech has again produced the sized Yttrium oxide particles. The expense of recent production and conversion to and assay of radioactive Y-90 changes has been borne by Abbott Laboratories. Appreciation is also expressed to the staff and administration of Piedmont Hospital, Atlanta, Georgia, for their generous help and cooperation.

1938 Peachtree

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TODAY'S MEDICAL ECONOMICS

One of the critical problems facing medicine today is the growing tendency of the working man to equate health care with a municipally owned service while at

the same time demanding discount house prices.—Justin C. Smith, Dean, Law-Medicine Center, Western Reserve University.

QUALITY CONTROL IN THE CLINICAL LABORATORY

Patisue Jackson, M.T. (ASCP), Atlanta

- ***Before a laboratory sets up a program of "quality control" the personnel must first take an objective and critical view of its present condition.***

FOR THE PAST FEW YEARS we have heard and read much about "quality control" as it concerns the various departments of the clinical laboratory. The term "quality control" has been borrowed from industry where it was of major significance during World War II. Gradually it extended into other fields and for the past several years now it has become part of the vocabulary of the clinical laboratory. I do not mean to imply, however, that some form of control did not exist in our laboratories before this time.

Quality control may be defined as the sum total of all efforts used to indicate that minimal error has occurred in the performance of a given laboratory test. Therefore, this assures that any abnormal result that is obtained by performing the test represents a true abnormality in the specimen concerned.

Quality control includes an awareness and close supervision of all factors relating to the collection of blood samples, the actual test procedure, and the reporting of the test results.

The following are factors the average technologist accepts as routine practice in a laboratory, but they are actually methods of controlling or minimizing errors. These are re-emphasized daily and are important to the quality control program.

1. The proper identification of the patient. Wrist bands, bed tags, and the like are methods of identification but should not be relied on completely. The patient should be asked to repeat his name and other identifying information may be found in friendly conversation and on the request slip.
2. Obtaining a correct and representative specimen from the patient. This will enable

the laboratory to have the required amount of specimen, collected in the proper manner and will not cause any additional discomfort to the patient.

3. Properly identifying the specimen. A paper label pasted to the tube with the patient's full name, room number, doctor's name and any other necessary identifying information is imperative. This should be placed on the tube before the technologist leaves the bedside of the patient.
4. Performing an accurate analysis on the specimen. This will be influenced by the quality of both the person performing the test and the equipment and procedure available.
5. Properly reporting the results of the analysis. Many times clerical errors cause the physician to doubt the accuracy of the laboratory. All results should be reported promptly, correctly, and using the correct nomenclature.
6. Maintaining permanent records of all laboratory test results. This is for present use of comparison and evaluation and also for future reference.

There are two main reasons why a clinical laboratory may wish to adopt a program of "quality control." The first reason is for the protection of the patient. A control provides an assurance that a normal or abnormal result is representative of the true events in the body of the patient.

Every technologist has experienced the problem of being confronted by the clinician who cannot accept a result as valid because it is completely incompatible with the rest of the clinical picture. All too

frequently, this results in subjecting the patient to the discomfort of another venipuncture, and possibly necessitating the delay of the patient's breakfast again, and sometimes an additional charge to the patient for laboratory services. To the laboratory worker, these may appear to be relatively minor inconveniences. To the patient, however, they may be the cause of undue apprehension that may inhibit progress toward recovery. Conscientious application of laboratory controls will eliminate the majority of such problems.

The second reason for adopting a control program is to allow the laboratory to constantly evaluate itself. A control program may provide a reference for checking standard procedures. It may allow for the comparison of procedures with those of another laboratory. A control program can serve as a guide for clinical evaluation as compared with published results. It can help to indicate where the errors may be occurring. It can provide a standard of comparison for evaluating new or improved procedures. And last but not least, it offers encouragement to the development of morale and pride of accomplishments within the laboratory staff.

The importance of quality control measures in clinical chemistry has been emphasized by Freier and Rausch.¹ Ross and Zwerneman² have emphasized the importance of a control method for use in the prothrombin concentration test. It is important that all laboratory procedures be controlled in some degree. Some, particularly biochemical procedures, can be controlled to a great degree; others cannot be controlled as well at the present time, for example cytology and microbiological procedures.

Attempts are being made to have adequate controls in all areas of laboratory work. For any procedure which cannot be controlled to *any* degree should *not be used* in the clinical laboratory.

Methods Vary

The methods used in a quality control program can be varied and should be the most convenient methods that can be adapted to the routine of the particular laboratory. The more controls a laboratory can run, the better its overall quality of work will be. However, the technologist should not be overloaded with long involved procedures of quality control — this would defeat the purpose of the entire program.

One of our most popular methods for quality control is the use of commercially available standards and controls. Even the smallest laboratory can with these aids develop an adequate quality control program. A standard solution prepared from pure,

dried chemicals can be run with each group of tests and these used as reference values in the calculation of the unknown specimens. Using standard solutions to standardize each group of tests, rather than relying on a permanently established calibration, compensates for many technical variations in the conditions from one run to another.³

Commercial Standards

Commercial standards and controls are available for chemical analyses, hemoglobin determinations, prothrombin concentration tests, and various serology tests (VDRL, ASTO, etc.). These commercial controls do have certain advantages. They are easily stored and require no special equipment. They are of known values and are stable. They are convenient and do not require costly preparation time. And, if bought in large quantities of the same lot number, the same analyzed values may be retained for a longer period of time.⁴

It must be remembered that when using a commercial product the manufacturer's directions must be followed to the letter to assure the best results.

An excellent means of quality control is the use of "reference methods." This is the comparison of the results of one laboratory with the results of an acceptable reference laboratory. Such comparisons will probably be made only occasionally. Also, parallel determinations may be done in the same laboratory using two different methods. Many times this is too time consuming and expensive to be practical. There are other methods that are more practical for the average laboratory.

The use of daily records or control charts is also a means of quality control. Daily records should be set up in each division in the laboratory.

An example is as follows:

Date	Patient's Name	Hct	Hgb	WBC	RBC	etc.
	"Control"					

By watching these columns from day to day definite "trends" toward consistently higher or lower values may be detected. They may give an indication of the necessity for recalibration of curves, that the instrument is in error, that there is error in the technique employed or that the reagents are in error. It may be pointed out here that control charts measure precision rather than accuracy and should not be the only means of control used in the laboratory.⁵

The use of evaluations as a means of determining work quality has been applied in the field of syphilis serology for several years. This method has been slow to be recognized as a useful tool in other phases of laboratory work. Belk and Sunderman⁶, however, did conduct an evaluation in Pennsylvania in 1946 in which they included six chemistry

determinations along with a hemoglobin determination.

The use of standard deviations in the clinical laboratory is advocated by Dr. Bradley Copeland who has been active in promoting better quality laboratory work for many years. According to Dr. Copeland⁷ standard deviations are determined on a series of paired samples as follows:

1. Have the technologist run 10 routine analyses in duplicate.
2. Take the difference between each set of duplicate measurements (d).
3. Square these differences (d²).
4. Add the squares of the differences to get the sum, which is written
 $\Sigma(\text{difference between duplicates})^2$
or Σd^2 .
5. The formula for the standard deviation is:
Standard deviation =
$$\pm \sqrt{\frac{\text{Sum (difference between duplicates)}^2}{2 \text{ (number of pairs)}}$$

A number of "home-made" controls may be incorporated into the daily routine to eliminate errors. As examples, the cell suspensions used for confirmation or reverse grouping in Blood Banking. Or, the use of Sequestrene⁸ or ERTA* as an anticoagulant in the hematology laboratory. In this the blood is stable for at least 24 hours and a repeat hemoglobin the following day is an excellent check. In the bacteriology laboratory controls are somewhat limited, but not lacking. Stock cultures may be carried in the laboratory with fairly good results. Smears of known organisms may be stained at the same time as unknown ones to determine the quality of the staining technique. In pregnancy tests using the male frog a known positive specimen may be obtained and run on a negative result frog to determine his reactivity.

These so called "home-made" controls are numerous and can be easily adapted into the routine work of the laboratory to assure quality work and results.

Before a laboratory sets up a program of "quality control" the personnel must first take an objective and critical view of its present condition. A review and evaluation of all laboratory procedures must be

made and determined which of these procedures can be closely controlled; which cannot. Intelligent and practical methods of control must be developed. It must be realized that there are limiting factors affecting accuracy in many laboratory tests. Step by step procedures for the quality control program should be written out. All personnel concerned with the program should become thoroughly acquainted with it.

Once a working program has developed the key to its success is constant, impartial and intelligent supervision. Laxity should not be permitted to develop even in minor aspects of the program or it will not be effective. Short cuts should not be taken to save time or to deviate from the program, as short cuts taken once and then repeated soon become part of the routine.

Reviews and re-evaluations of all aspects of the program should be made periodically. Thus, a constant improvement in the quality of work in the laboratory will be in action.

A general discussion of the nature of a quality control program in the clinical laboratory has been presented. Perhaps the most important factor in achieving a good program of quality control may be found in the mental attitude of the medical technologist. If a healthy attitude toward control measures is developed, the technologist will find the time — in spite of heavy workloads, lack of personnel, etc. — to use controls routinely and thus develop a high degree of accuracy in the clinical laboratory.

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* Disodium — ethylene — diamine — tetra — acetate.

NATIONAL HEALTH SERVICE GROWS COSTLY

A by-product of the British National Health Service often overlooked or purposefully ignored by American proponents of governmental medicine is that of an ever expanding bureaucracy to run their cradle-to-the-grave socialized medical program.

The Ministry of Health in Great Britain now employs 21½ clerks for every doctor in the island republic.

One person for every 400,000 Britains is employed by the Ministry of Health.

There is no evidence to support the belief that Americans would be any more efficient than the Britain's experience we would require the services of an additional 1,740,000 clerks to direct and administer a program of governmental medicine.

USE OF DEXTRAN IN PREVENTING THROMBOSIS OF SMALL ARTERIES FOLLOWING SURGICAL TRAUMA

Milton F. Bryant, M.D. Walter L. Bloom, M.D.
Spencer S. Brewer, Jr., M.D. *Atlanta*

■ *These favorable preliminary findings may lead to important clinical applications.*

IT IS GENERALLY agreed that surgery upon arteries 3 mm. or less in external diameter is usually unsuccessful because of the development of post-operative thrombosis. The high incidence of post-operative thrombosis in small arteries has limited the surgeon in his efforts to treat segmental obstructive lesions in the tibial, coronary, cerebral and mesenteric arteries. A number of workers^{1,2,3,4} have tried various methods of preventing this post-operative complication; however, to date no method has been devised that is entirely successful.

Injury of sufficient magnitude to endothelium results in platelet agglutination, platelet lysis and initiation of clot formation. As a result of extensive laboratory and clinical experience with dextran, one of the authors (WLB)^{5,6,7} speculated that this non-polar polysaccharide might be effective in forming a mono-molecular layer on the endothelium and thereby help prevent intravascular thrombosis. In addition, it was felt that dilution of clotting components by a hemodiluting polysaccharide might further serve to diminish clot formation. This study was undertaken to determine if clinical dextran would prevent thrombosis in small arteries subjected to a standardized mechanical trauma.

Materials and Methods

Method A: Mongrel dogs weighing between 20-25 pounds were used in this study. Induction and main-

tainance of anesthesia was accomplished with nembutal given intravenously. The femoral arteries were exposed and carefully dissected proximally and distally so as to be able to isolate a 2 cm. segment that measured 3 mm. or less in external diameter. Side branches were ligated with #5-0 arterial silk. Bulldog clamps were applied and a longitudinal arteriotomy incision was made in the isolated segment. A #15 knife blade was used to remove mechanically all of the intima from the isolated segment. The arteriotomy incision was closed with #7-0 arterial silk in a continuous fashion.

The bulldog clamps were released and a pulsatile flow of blood was restored through the traumatized segment. The vessel was kept moist with saline and observed until thrombosis of the segment occurred. The time for an occluding thrombus to form was recorded in each study. Thrombosis was determined by palpation and inspection.

Method B: In order to determine the effect of clinical dextran in preventing thrombosis, a group of dogs were prepared as described in the control animals. Prior to completing the intimestomy in 20 dogs, an intravenous infusion of clinical dextran was given. In group one, six dogs with 12 intimestomies were given dextran in quantities equal to three per cent of their body weight. In group two, six dogs with 12 intimestomies received an I.V. infusion of dextran equal to two per cent of body weight and in group three, eight dogs with 16 intimestomies received a quantity of dextran equal to one per cent

This investigation was supported by U.S. Army Contract #DA-49-193-MD-2168.

of their body weight. The arteries were observed for patency at the end of two, 24 and 48 hours. A number of arteries (eight) were observed at intervals for five days; however, it was found that if the artery was patent at 48 hours, it was invariably patent three days later.

Coagulation Studies: An Owren Thrombotest assay, a thrombin time (Fibrinogen assay) and thromboelastographic studies (Fig. 1) were performed on

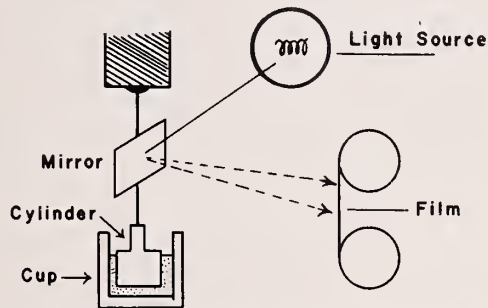


Figure 1. Schematic mechanism of the Thrombelastograph. The cup is motor driven to oscillate $4^{\circ} 45'$ on its own axis back & forth every 9.0 seconds. Plasma sample is placed in cup, recalcified, and recording begun.

control dogs, as well as on representative dogs in group one, two and three. These studies were performed before giving dextran and one and 24 hours after infusion of dextran. In three dogs coagulation studies were performed four days after the dextran infusion. Blood dextran levels were determined along with the coagulation studies in selected instances.

Results

In 20 mongrel dogs 40 intimestomies were performed and thrombosis of the intimestomized segment occurred in 38 arteries within one hour after restoration of a pulsatile blood flow. Most of the vessels developed an occluding thrombus approximately 20 minutes after removal of the bulldog clamps. Two vessels did not develop an occluding thrombus until two hours after completing the intimestomy. Several specimens were extirpated, fixed in formalin and studied microscopically. The one hour thrombosis rate in these control animals was 95 per cent.

Dextran in quantities equal to one, two and three per cent of body weight produced a reduction in thrombin time. The average thrombin time for all doses of dextran was 4.1 seconds as compared to 5.4 seconds for normal controls. The "prothrombin time" averaged 19.5 seconds using the Owren Thrombotest assay as compared to a normal control average of 16.9 seconds. The thromboelastographic pattern was consistently changed by dextran, as shown (Fig. two, three.) This animal received an infusion of dextran equal to two per cent of his body weight. The r value is slightly shortened. Change in the k value is related to the decrease in ma . With the marked reduction of the ma value an

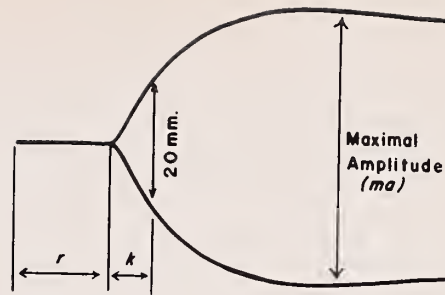


Figure 2. Scheme of a normal thrombelastogram. The reaction time (r) indicates the time interval between recalcification of plasma and the first signs of resistance. The clot formation time (k) is that section of the curve which lies between r and a point where the curves are 20 mm apart. The maximal amplitude (ma) is value related to clot elasticity.

increase in the k value was noted. A reduction in the ma value is always obtained and is directly related to the quantity of dextran infused. If large amounts of dextran are given, the ma value drops almost to zero.

Determination of blood dextran levels confirms the inverse relationship between concentration of dextran and ma value. As the concentration of dextran in the plasma increases there is a constant and gradual reduction in the ma value. In addition, even with a large concentration of dextran in the plasma there is generally a shortening of the reaction time, and on some occasions with large doses only slight r prolongation such as can be attributed to plasma dilution alone.

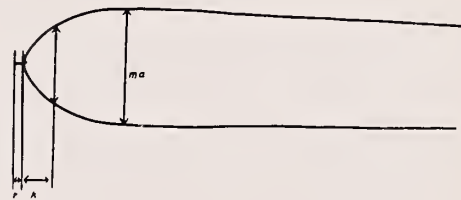


Figure 3. Thrombelastographic pattern following infusion of dextran. The r value is shortened, the k value is increased and the ma value is markedly reduced.

Discussion

The method of Deaton and Anlyan⁸ for producing thrombosis in small arteries were modified in our study by using a longitudinal arteriotomy because of the difficulty in removing the intima completely through a transverse arteriotomy. In addition #7-0 rather than #5-0 arterial silk was used to close the arteriotomy.

Various methods have been used in an effort to prevent post-operative thrombosis in small arteries subjected to surgical trauma. Trypsin and the coumarin-type drugs are not effective and Deaton and Anlyan³ have found heparin to be relatively ineffective. Their studies indicate that fibrinolysin therapy may be an important aid in the prevention of thrombosis in small arteries after surgical trauma. Jacobson² and his associates have successfully used

the dissecting microscope as an aid in the surgery of small arteries.

Our animal studies suggest that dextran provides the first practical economical and simple method of effectively preventing post-operative thrombosis in small arteries. The patency rate following administration of dextran was 90 per cent (40 intemectomies). Dextran infused in quantities equal to one per cent of body weight is apparently just as effective as a three per cent infusion in preventing thrombosis.

None of the dogs given a one or 2 per cent of body weight infusion of dextran showed an abnormal bleeding tendency at operation. Dogs given a three per cent dextran infusion did have a tendency to bleed somewhat freely during surgery but the bleeding was not excessive. Dogs given a five per cent infusion of dextran bled excessively.

Thromboelastography⁹ is a valuable means of documenting permanently the behavior of the clotting mechanisms as a whole. In the quantities used in these experiments, it was found that dextran constantly reduces the *ma* value, the degree paralleling the amount infused.

The failure to produce prolongation of the *r* value would certainly stand as strong evidence against any significant interference by dextran with the action of those moieties which initiate clot formation. The actual shortening of the *r* value in many instances cannot be easily explained since such a phenomenon has otherwise been seen only as a rebound phenomenon on heparin withdrawal.

A definite explanation as to the mechanisms by which dextran is effective in preventing thrombosis in the reported experiments cannot be offered. The total plasma volume was undoubtedly increased with the consequent dilution of all of the clotting factors. It is unlikely that the amount of dilution produced could account for the observed "anti-thrombotic" properties of dextran.

One must consider the possibility of dextran having a "siliconizing or coating effect" on the formed elements of the blood and on the denuded vessel wall by formation of mono-molecular coating. A number of workers^{10,11} have shown that dextran increases the suspension stability of blood and prevents intravascular aggregation following various types of trauma. In the published studies, low molecular weight dextran has been reported to be more effective in preventing sludging than clinical dextran. Long and associates¹² feel that dextran prevents corpuscular aggregation by interfering with the development of adhesive properties on the surface of the corpuscles. Löfström¹³ and Gelin¹⁴ state

that intravascular aggregation following tissue trauma is due to the accumulation of large protein molecules which increase the viscosity of the plasma. Whatever the mechanism of action, dextran is a promising agent in preventing thrombosis in small arteries following surgical trauma.

Clinical dextran (0.6 per cent of body weight) has now been used with apparent success in four patients who had thromboendarterectomies performed on arteries measuring 3 mm. or less in external diameter. Studies are now in progress comparing the effectiveness of clinical dextran and low molecular weight dextran in preventing thrombosis in small arteries subjected to surgical trauma.

The coagulation studies done here were originally designed as a means of laboratory control of the dextran administration. However, no need for *individual control* seems necessary. Another objective was to elucidate the nature of the hemorrhagic effects previously attributed to dextran. The thromboelastographic measurement of the changes induced in the coagulation mechanism *as a whole* has stimulated more study to determine whether or not alteration of platelet physiology is the primary cause for the *in vitro* coagulation defect. If so, perhaps this is the primary "therapeutic" effect being observed *in vivo*.

Summary

1. Forty experimental preparations were performed in 20 dogs. Three millimeter segments of the femoral arteries were subjected to arteriotomy and intemectomy. Post-operative thrombosis occurred in 38 arteries giving a thrombotic rate of 95 per cent.
2. Forty similar experimental preparations were performed in 20 dogs and clinical dextran was given. Post-operative thrombosis occurred in only four arteries giving a thrombotic rate of ten per cent or a patency rate of 90 per cent.
3. These studies suggest that clinical dextran is of value in preventing thrombosis in small arteries following surgical trauma.
4. Thromboelastographic studies show dextran to have a constant effect on the coagulation pattern.
5. Clinical dextran has been used in four patients with apparent success.

Clinical dextran used was Gentram, average molecular weight 75,000. Supplied by Baxter Laboratories.

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CORRECTION OF DEAFNESS IN OTOSCLEROSIS BY STAPES REPLACEMENT

Claude L. Pennington, M.D. *Macon*

■ A report of 100 consecutive cases.

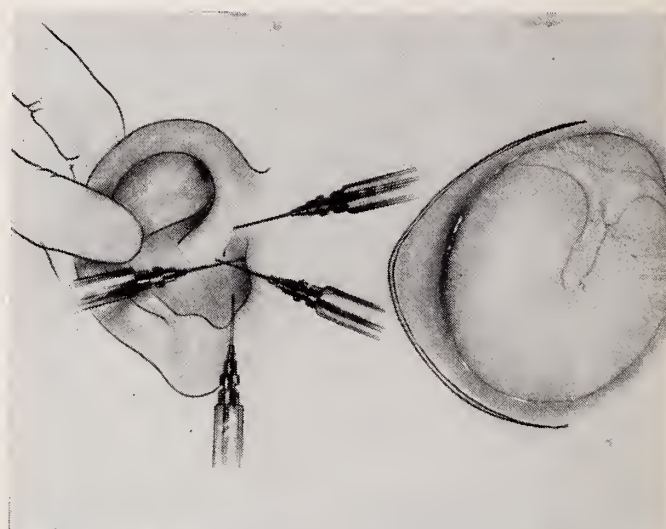
OTOSCLEROSIS, A DISEASE of the bony inner ear capsule of unknown etiology, produces a progressive, conductive hearing loss, which manifests itself during the productive period of adult life. It is the most common cause of conductive deafness in young adults. The mechanism of this hearing loss is fixation of the normally mobile stapes in the oval window frame by an overgrowth of bone so that transfer of sound from the eardrum through the ossicular chain to the inner ear is impeded. Effective methods of re-establishing the sound conducting mechanism have evolved so that now 94 per cent of patients seeking relief from this hearing loss are assured of a practical, serviceable gain in hearing from surgery.

Historical

In 1890 Miot of France⁶ and in 1893 Jack of this country⁴ reported a series of operations on the stapes and oval window with initially good results. Others too attempted oval window procedures, but by 1900, possibly because of the increased incidence of staphylococcal and streptococcal infections in the general population, the lack of antibiotics, adequate high magnification, and light in the operative field, all of this work was abandoned.

Holmgren of Sweden² and Sourdille of France¹⁰ in the early part of the 20th century proposed fenestration of the semicircular canal system as a method of bypassing sound around the diseased oval window. On their experimental work Lempert in 1938⁵ perfected a practical, one-stage fenestration operation, which is still practiced today. This operation has given countless thousands practical hearing.

Attempting to verify a diagnosis of otosclerosis prior to fenestration operation, Rosen in 1952, using an approach through the ear canal, (Figure 1) exposed and palpated the stapes for fixation.⁷ While he was doing so, the stapes was mobilized and hear-



Incision on posterior ear canal wall — local anesthesia

FIGURE 1

ing improved. This improvement has been maintained to the present. Through Rosen's serendipity, the door to surgery on the stapes and oval window was reopened after a sixty-year lapse of interest in this approach. Since that time, the original technique of Rosen, which was merely an exploration, palpation, and attempted mobilization of the entire stapes, has passed through many revolutionary stages ranging from simple total mobilization of the stapes to complete stapedectomy with a surgically reconstructed sound-conducting mechanism. Some procedures remain as valuable techniques, while others have been discarded after they were proved of no lasting value. This rapid evolution has come about as an attempt was made to obtain a higher percentage of initial and permanent hearing improvements without damage to the delicate inner ear structures. Rosen's operation of stapes mobilization gave improvement to approximately 30 per cent of cases, but regression of hearing in one or two years was obvious in at least 90 per cent of these cases. The

Basek-Fowler anterior crurotomy (Fig. 2) gave 60 per cent to 70 per cent initially good results, but here too regression and technical problems have made it an unpredictable procedure in the best

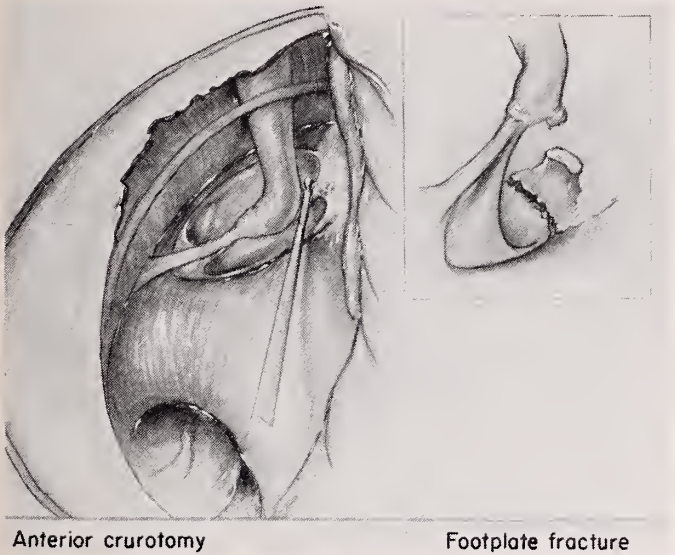


FIGURE 2

hands.¹ Partial stapedectomy gave 80 per cent of cases a marked hearing improvement with but few regressions. Polyethylene tubing, as described by House, replaced the upper crural segments of the stapes footplate for sound conduction³. This procedure was a predictable operation except in cases where disease or anatomy would not allow placement of the small plastic strut in the proper position on an area of normal footplate (Fig. 3). In these

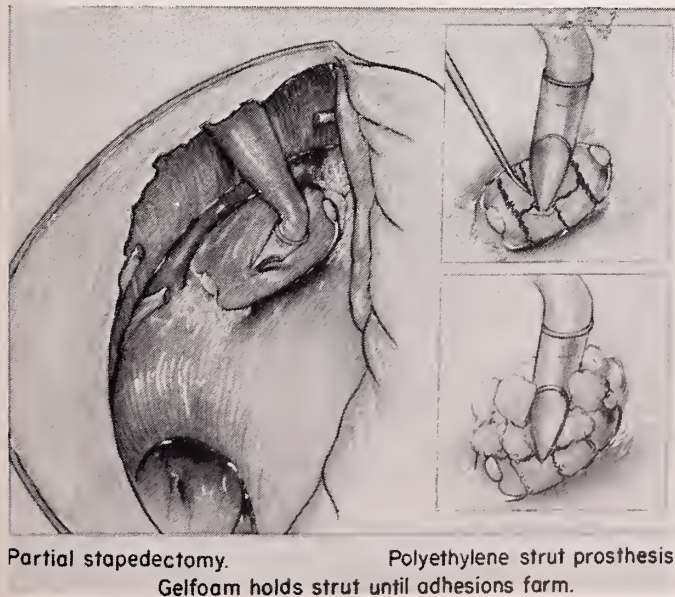


FIGURE 3

cases to improve hearing the entire footplate had to be removed and a soft tissue graft placed over the oval window, as advocated by Shea. The conducting mechanism was reconstructed with a piece of polyethylene tubing⁹ (Fig. 4). It soon became obvious to most otologic surgeons that, if the procedure of

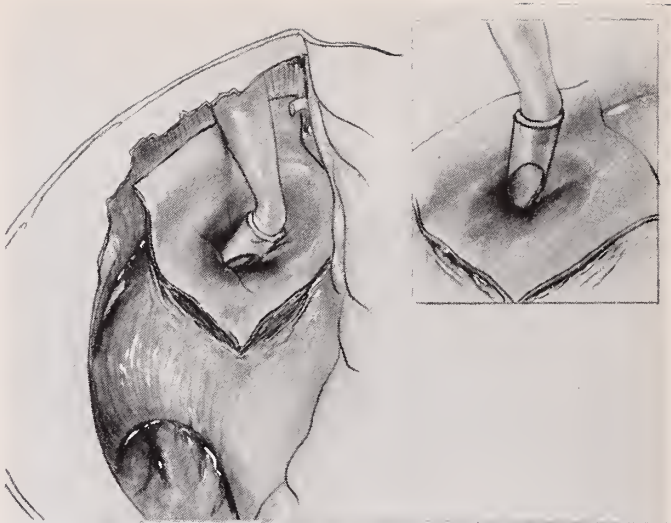


FIGURE 4

total stapedectomy with graft and prosthesis was a highly predictable procedure in advanced cases, it might be even more suitable in minimal and moderately advanced cases. Experience has proved this contention.

Steel Wire — Adipose Tissue Prosthesis

Minor differences in technique have arisen in performing total stapedectomy. Some, after the technique of Shea, have used a thin vein across the oval window following removal of the footplate of the stapes. A polyethylene tube, supported by the vein and attached to the incus, reconstitutes the sound conducting mechanism. Certain technical, anatomical, and pathological considerations have led others, including myself, to use a stainless steel wire attached to the incus and an adipose tissue graft in the oval window after the technique of Schuknecht⁸ (Fig. 5). I have found the advantage of this latter technique over vein graft to be fourfold: 1. A deep, narrow oval window need not be surgically created into a huge saucer with a drill to accept the rather large polyethylene strut and relatively thick vein graft. 2. The graft of adipose tissue fills the oval window frame, but unlike the vein graft does not extend onto surrounding middle ear structures and fill the oval window niche to be replaced later by normal mucosa or scar tissue. The oval window is more effectively sealed by the adipose tissue graft, and perilymph leakage is greatly reduced. Normal mucous membrane of the middle ear covers the adipose graft within ten days. 3. There is immediate, permanent attachment of the graft to the incus through the wire prosthesis. 4. The wire tissue graft technique can be adapted to any anatomy, the anatomy of the ear not being adapted to the implant as in the vein graft procedure. Any procedure which requires less surgical manipulation with correspondingly good results is the most acceptable in my opinion.

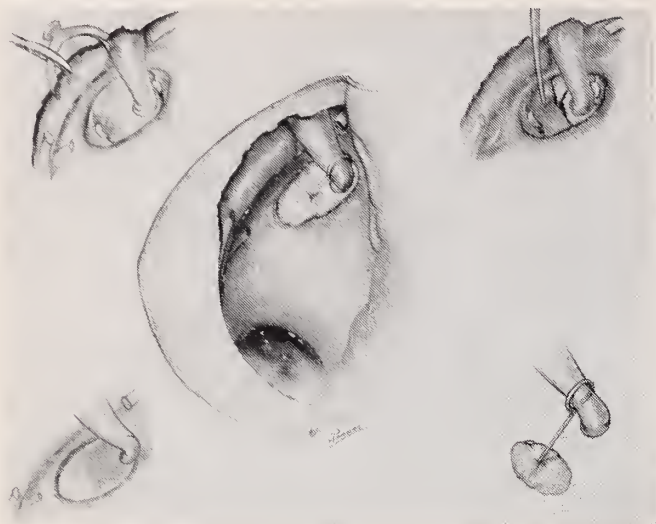


FIGURE 5

Upper Left: Stapes crura fractured and removed.

Upper Right: Footplate fractured and removed with a pick.

Lower Left: Oval window completely opened.

Lower Right: Adipose tissue graft with steel wire prosthesis attached to incus.

Center: Completed operation. Adipose graft fills the oval window. Steel wire is attached to the incus.

Pre-Operative Examination

Before any surgery is performed, adequate history, physical, and audiometric examinations are essential. In otosclerosis there is a history of slowly progressive hearing loss bilaterally, usually beginning in one ear and later appearing in the other. This hearing loss is unassociated with colds or ear infection. Patients usually hear well in noisy places but can rarely carry on conversation while eating. Tinnitus may be present in one or both ears. Eardrums are normal on examination. Tests with a 512 tuning fork are performed. Bone conduction is better than air conduction in otosclerosis.

Pure tone air and bone audiometrics are routinely done. Speech reception threshold and speech discrimination scores are determined by the use of accurately recorded speech fed through the audiometric circuits. The later tests are necessary to determine operability and post-operative results. All surgical cases should have these tests pre-operatively and post-operatively.

Technique of Stapes Replacement

The ear is prepared the day before surgery with a solution of Phisohex. After the ear has been dried, Chlormycetin powder is sprayed into the ear canal and a sterile piece of cotton is applied to the external auditory canal. The patient is admitted to the hospital the evening before surgery. The next morning in the operating room with the patient under heavy sedation, the ear is again irrigated with Phi-

sohex solution followed by tincture of Methiolate. The hair is not shaved around the ear but is held back from the ear with lubricating jelly. Careful detail to sterile technique is observed with adequate draping. Anesthesia is achieved with two per cent Xylocaine in the posterior ear canal wall given with a 26 gauge needle. A triangular flap of skin from the posterior ear canal wall (Fig. 1) is elevated, and the posterior one-half of the drum is lifted forward. Bleeding is controlled at skin edges with cautery and gelfoam. The posterior bony ear canal wall in the area of the incision is removed with a drill and with sharp curettes to expose the oval window and facial nerve. The round window is observed for patency. The stapedia tendon is cut. The chorda tympani nerve is retracted or cut depending upon its interference with the field of vision. The posterior crus of the stapes is cut and then the incudostapedial joint is dislocated. The superstructure of the stapes is then removed following fracture of the anterior crus with a blunt pick (Fig. 5). The footplate is then carefully examined, and the mucosa of the footplate and oval window is removed as high as the facial nerve on the upper side and for approximately one millimeter on the promontory on the lower side. The footplate is perforated with a sharp pick or drill. With small angle picks it is removed, all bleeding being carefully controlled. An adipose graft one and one-half by three millimeters previously taken from the earlobe is attached to a piece of #36 stainless steel wire four and one-half millimeters in length. A small hook on the opposite end has been fashioned on a die so that it fits exactly over the long process of the incus. The tissue graft and stainless steel prosthesis is then inserted with the adipose graft fitting into the oval window. The stainless steel wire prosthesis is then placed over the incus and crimped into its final position with a small pair of forceps. The graft is carefully adapted to the oval window; and the mucous membrane, previously retracted, is spread across this graft, effectively sealing the oval window. The ear canal flap is then placed back in its normal position, and a small piece of cotton is placed in the ear canal.

Post-Operative Course and Complications

After surgery (ten to 12 hours) the hearing improvement observed in the operating room is lost due to the accumulation of serum and blood in the middle ear but is regained on approximately the twelfth day when the middle ear transudates resolve. Low tones appear to return first, while high frequency sounds slowly return between the first and third month. There is slight positional vertigo in some patients for 24 hours but much less than in vein graft cases, in my experience. The patients are

allowed out of bed after the first 24 hours for bathroom privileges and are discharged 48 hours after surgery. My patients are kept on a broad spectrum antibiotic (Pan Alba) for five days. Complications in this series of 100 consecutive cases have been few. One patient experienced moderately severe vertigo for four days following surgery requiring an extension of hospitalization for 48 hours. Her vertigo since that time has cleared up, and her hearing has reached a normal level. Another patient developed middle ear infection on approximately the tenth day following surgery with a resulting perforation of the eardrum. This perforation has subsequently been repaired, and the patient's hearing has improved to the expected level. Because a third patient had marked amounts of perilymph fill the middle ear on fenestration of the footplate, cessation of surgery was required before a graft could be placed over the oval window. Although this patient experienced no hearing loss following the procedure, no further surgery is contemplated on this ear. A fourth patient had good hearing acuity but poor speech discrimination following surgery. Surgery in this case was difficult, and much drilling was necessary to open the oval window.

A small amount of blood in the inner ear at the time of surgery, previously considered deleterious to inner ear function, seems to produce no reaction as long as perilymph is not aspirated and blood allowed to fill the labyrinth. Small pieces of footplate, inadvertently pushed into the vestibule during extraction of the footplate, seemed to produce little detectable reaction. It is of course best to avoid these problems by good exposure and meticulous control of hemorrhage and care during footplate extraction. These procedures for the occasional operator are fraught with pitfalls and, in my opinion, should not be attempted by those not initiated in previous oval window and fenestration surgery.

Results

In 100 consecutive cases, 94 per cent of the patients achieved a satisfactory correction of their conductive hearing loss by total stapedectomy and stapes replacement with adipose tissue graft and stainless steel wire prosthesis. A case was considered satisfactory after surgery if hearing was within ten decibels of cochlear function at speech frequencies. The earliest cases have maintained their improvement for more than one year.

Results of One Hundred Consecutive Cases

- I. Initially successful operations
(one month post-operatively) 97%

- II. Initially unsuccessful operations
(One month post-operatively) 3%
Cause: 1. Round window closure 2%
2. Poor speech discrimination after surgery on ear with advanced otosclerosis requiring more than average oval window drilling. 1%
- III. Late Failures* (three months to one year)
Cause: 1. Oval window closure from active overgrowth of bone or dense scar tissue following surgery 3%
- IV. Cases maintaining hearing gain from three months to one year 94%

* I anticipate that several additional cases will be added to Group III as time passes.

Conclusions

Total stapedectomy with reconstruction of the ossicular chain by tissue graft to the oval window and stainless steel wire prosthesis to the incus is a safe and highly predictable procedure for the experienced otologic surgeon. It offers the greatest opportunity for correction of hearing loss in otosclerosis at the present time. Ninety four of 100 consecutive cases have achieved normal hearing by the above described procedure and have maintained this improvement for one year in the earliest cases. Total stapedectomy with adipose tissue graft and wire prosthesis is the procedure of choice in otosclerosis surgery because it eliminates the guesswork of the partial operations, it produces a more secure graft with less danger of perilymph leakage, and it requires less surgical adaptation of middle ear structures than the vein graft operation. This technique is the best, in my opinion.

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BLOOD FOR OPEN HEART SURGERY

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- ***No serious transfusion reactions and very few episodes of severe bleeding have been encountered in the author's experience.***

SPECIAL BLOOD BANKING procedures are necessary for open heart surgery to avoid the complications that are encountered with massive transfusions. The complications of massive transfusion with ordinary bank blood fall into two categories — 1. hemorrhagic phenomena, and 2. citrate intoxication.

Bleeding resulting from massive transfusion is the result of multiple derangements of coagulation. Usually several coagulation factors are lacking and fibrinolysis is often present. The deficient coagulation factors are usually platelets, anti-hemophilic globulin, and Factor V or labile factor.

Even with the best of available techniques, platelets cannot be preserved in adequate numbers for more than a few hours. This alone is a very serious deficiency in bank blood. Significant thrombocytopenia occurs almost invariably in patients who receive 14 or more transfusions in a few hours time, is frequent after eight pints, and may occur after only two pints. Platelets can be preserved in adequate numbers for a few hours in blood collected carefully by gravity into plastic bags or siliconized containers. Optimally such blood should be used within three to four hours of collection, though some platelets will still be present 24 to 36 hours later. It is a good rule to use such blood for subsequent transfusions when a patient has received six or more units of bank blood in a short period of time. It is also wise to use fresh blood in a plastic bag for any patient in whom massive transfusion can be anticipated. This technique also permits the administra-

tion of blood which is rich in other unstable coagulation factors.

Citrate intoxication may result from massive transfusions of citrated blood. Normally the body is able to dispose rapidly of large amounts of citrate, chiefly by metabolism by the liver and excretion by the kidneys. Ability to handle citrate is reduced in renal disease and when the metabolic processes of the liver are impaired. Metabolism of citrate is reduced in liver disease, in surgical procedure which involve interference with hepatic blood flow, and in hypothermia. In any of these situations, the administration of several units of citrated blood, at the rate of 500 cc. per 30 minutes or faster may result in citrate intoxication. At faster rates of administration citrate intoxication may appear in otherwise normal individuals.

The diagnosis and treatment of citrate intoxication are difficult problems. These patients are usually in shock or under anesthesia and the obvious sign of tetany is often not seen. The most common indications of the diagnosis are hypotension and cardiac arrhythmias. The treatment is the immediate administration of intravenous calcium. The amount of calcium required is widely variable. Unfortunately there are no reliable guides to adequate therapy. Fatalities occur from unrecognized citrate intoxication and as a result of either too little or too much administered calcium. The best plan is to give one gram of calcium for every 1,500 to 2,000 cc. of citrated blood. Certainly in open heart surgery, where 2,000 cc. of blood or more is suddenly placed in circulation, the use of citrated blood is to be

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avoided. The most satisfactory procedure is to use heparinized blood.

Therefore, to avoid the problems of coagulation factor deficient blood and citrate intoxication, fresh heparinized blood collected by gravity in plastic bags or siliconized bottles should be used.

The necessity for fresh blood raises serious problems of donor procurement. The amount of blood needed varies depending upon the patient's size and cardiac defect, but generally about 19 pints of blood are required for this operation. As a rule we collect 11 pints in a heparin solution for use in the extracorporeal circuit. Four pints are collected in ACD solution for use before and after the period of cardiopulmonary bypass. The other four donors are kept immediately available in case unanticipated problems arise.

Ideally patients who are to have open heart surgery are seen for hematologic evaluation at least one month prior to surgery. Part of this evaluation is the determination of the patient's ABO and Rh blood type. The blood of all donors must be compatible with patient at least in ABO and D types, and by saline and Coomb's cross-match. In addition it is recommended that the blood of all donors which is to be used in the extracorporeal circuit be inter cross-matched. This may be done by using mixtures of up to five bloods. Prospective donors are seen one to two weeks prior to surgery and all preparations are completed several days to a week before the date of operation. The donors return to the hospital to make the donation of blood one to two hours before the operation.

Studies of the hemostatic mechanism are also carried out at the patient's initial visit. Not infrequently patients with cyanotic congenital heart disease have thrombocytopenia. Occasionally other patients are found to have thrombasthenia. Additional blood will be needed for these patients for preparation of platelet concentrates. Patients who have been in chronic congestive failure often have hypoprothrombinemia which may be corrected preoperatively. Occasionally other hemostatic abnormalities may be found which can either be corrected preoperatively or especially prepared for at the time of surgery.

Using the methods here outlined experience with

open heart surgery has been very satisfactory. In approximately 100 cases we have encountered no serious transfusion reactions and very few episodes of severe bleeding. There have been no deaths directly attributable to bleeding. Bleeding may have contributed to the death of one patient. All other bleeding episodes have been successfully managed. Postoperatively there is almost always a prolonged plasma prothrombin time and frequently a moderate degree of thrombocytopenia. Serious bleeding due to those abnormalities is unusual. The plasma prothrombin time and platelet count are usually back to normal in 24-48 hours. Fibrinolysis occasionally occurs, but is usually of brief duration and mild. Occasionally the administration of concentrated fibrinogen is necessary for this problem. Of course, if there are any rough surfaces in the extracorporeal circuit, or if the patient is not adequately heparinized, clotting may occur in the pump with resulting depletion of many coagulation factors. Particular care is necessary in the use and preparation of the proper equipment. The patient should be heavily heparinized. We have found it best to use five mg. of Heparin per kg. of body weight. At the end of the cardiopulmonary bypass, the Heparin must be accurately neutralized. The amount of Protamine necessary to neutralize a given amount of Heparin varies considerably from one batch of Protamine to another. Protamine in high concentration is an anticogulant. Therefore, a Protamine titration test is necessary for guidance in accurate neutralization of Heparin. Since 15 or 20 minutes are required to perform this test, an empiric dose of Protamine must be given as the patient comes off the pump. A Protamine titration test should be done about five minutes after this injection. Then, if there is subsequent bleeding, it will be possible to tell whether this is the result of too little or too much Protamine.

Open heart surgery is a complicated procedure. There are many technical details which demand the attention of the thoracic surgeon, the anesthetist, the cardiologist, and the hematologist. However, by means of painstaking attention to details, this surgery can be performed with great benefit to many previously hopeless patients.

1667 Alderbrook Road, N.E.

DEPARTMENT OF OPHTHALMOLOGY OPENED AT MILLEDGEVILLE STATE HOSPITAL

The new staff Ophthalmologist at the Milledgeville State Hospital is Dr. Telfilo Tomas. The first resident is William D. Heath. The second resident is Dr. Stanly Finkel who will report for duty January 1, 1962. The Chief of Ophthalmology is Dr. W. Devereau Jarret of Macon, Georgia.

Each building at Milledgeville State Hospital is being

carefully screened for all cases of cataract and other pathology of the eye. These cases will be scheduled for surgery as quickly as possible and as required. The new Ophthalmology Service has its own fully equipped equipped surgical unit, where all cataract extractions and minor procedures are performed. Major surgical procedures of the eye are done in the Surgical Suite.

APLASTIC ANEMIA

E. Earle Lewis, M.D., *LaGrange*

■ ***A review of cases at Eugene Talmadge Memorial Hospital is presented.***

APLASTIC ANEMIA WAS FIRST described by Ehrlich in 1888. The striking thing he noted was the lack of reticulocytosis and the presence of nucleated red cells in the peripheral blood. Bone marrow was found to be markedly hypoplastic. Later it was noted that the same picture was produced by exposure to ionizing radiation, arsenicals and benzene derivatives. The term was then expanded to include all cytopenias with anemia of toxic or idiopathic origin. Perhaps a better term would be hypoplasia of the bone marrow, except for the fact that in 10-25 per cent of these patients the bone marrows are histologically normal or even hyperplastic. (One might assume that these latter cases result from a failure of maturation or release of cells from the marrow and perhaps this is true).

The mechanism responsible for the anemia is not well understood. With irradiation, benzene derivatives, and arsenicals it appears to be direct injury to the blood forming cells. Recent evidence would add chlormaphenicol to this group since it has been shown that large doses of chloramphenicol regularly produce marrow injury. By and large, however, chloramphenicol induced hypoplasias are primarily classified as drug idiosyncrasy. In the so-called idiopathic group the defect seems to be a failure of the marrow to respond to stimulation by erythropoietic substance. A number of studies indicate that the deficiency is in the marrow response, not in a lack of erythropoietin. Guerny and his group at Chicago report erythropoietic activity of plasma to be actually increased in three patients with hypoplastic anemia. The exception to this, however, may be in congenital hypoplastic anemia, a chronic normochromic, normocytic anemia usually occurring in the first few months of life and frequently associated with other congenital malformations such as absent digits and Faconi's syndrome. It is characterized by persistently low reticulocyte counts and is refractory to all treatment except

transfusions. Guerny proposes that this may be due to lack of erythropoietin. He has tested this hypothesis by giving anemic plasma known to be high in erythropoietic activity to two patients with congenital hypoplastic anemia. There was a definite reticulocyte response (up to four per cent with a transient rise in hemoglobin. The bone marrow also showed increase in erythroid activity.

It has been suggested by many that an antigen-antibody type reaction might be an etiologic factor in the acquired forms of aplastic anemia. This would explain the transient marrow hypoplastic seen following administration of certain drugs in small amounts. That this is a hypersensitivity is evident from the reproducibility of the effect with small amounts of drug, and the improvement following its discontinuance. There still remains the large number of idiopathic cases in which no history of exposure to any toxin can be obtained. It is theorized that these might result from autoimmunization or the formation of autoantibodies against one or more types of blood forming cells. Why this should suddenly happen is not clear; but it may be that the cell becomes slightly altered or injured by a drug or environmental factor so that it becomes antigenic. Credence to this theory is lent by the work of a group of investigators at Freiburg, Germany, who have demonstrated autoagglutinins against leukocytes, erythrocytes and platelets in a patient with aplastic anemia who had never been transfused. The autoantibodies against platelets have been demonstrated time and again in thrombocytopenia.

Two Groups of Aplastic Anemia

It would seem, then, that aplastic anemia can be classified into two groups: (1) congenital hypoplastic anemia, which may actually be a deficiency of erythropoietin; and (2) acquired aplastic anemia. The latter may be divided further into: (a) idio-

pathic, which may be due to autoagglutinins; and (b) toxic marrow depression, which is of two distinct types—direct injury to cells, as by irradiation or benzol, and hypersensitivity, as with drug idiosyncrasies. Chloramphenicol seems to bridge the gap between these last two types. Doubtlessly genetic makeup also plays a part in susceptibility.

Acquired aplastic anemia may occur at any age but appears to be more frequent in older persons. It is much more frequent in Caucasians than Negroes and far more common in males than females. The latter may be purely occupational in that males are more commonly exposed to various toxic agents than are females.

Review of Cases at Eugene Talmadge Memorial Hospital: 1956-1960

We have collected data on all cases of aplastic anemia at this hospital since it opened in 1956. Included are cases of aplastic anemia, pancytopenia, hypoplastic bone marrow, and toxic bone marrow depression. There was diminished erythropoiesis in all cases, and all cases but one had evidence of depression of at least one other marrow element. Five patients had severe depression of granulopoiesis with only moderate decrease in erythropoiesis. Secondary cytopenias from hypersplenism were excluded. There was one instance where the spleen was concomitantly enlarged, but it was felt that this was primary marrow hypoplasia — not hypersplenism. There were no cases of congenital hypoplastic anemia.

There were 30 cases of marrow hyperplasia in the series. Twenty two of the patients were Caucasian; eight, Negro. There were 19 males and 11 females. Age varied from three years to 79 years, but 21 of the 30 patients were over 16 years of age. Interestingly, in seven of the nine patients under 16, the disease was classified as idiopathic. The other two cases were secondary to chloramphenicol. A breakdown of etiologic classification was as follows:

- Idiopathic: 10
- Chloramphenicol: 6
- Insecticides (Benzene hexachloride, DDT): 5 (plus 2 possible)
- Sulfonamides: 2 (plus 1 possible)
- Aspirin, tetracycline, tapazole, Thio-Tepa (R), hair spray, radioactive phosphorus and cleaning fluid: 1 each

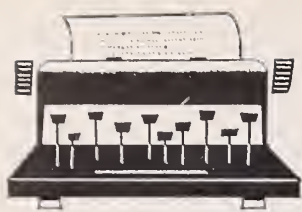
There is some doubt as to the true etiology in our cases of aspirin, tapazole, cleaning fluid, and hair spray; and perhaps these should be classified as idiopathic. Indeed it should be pointed out that in most cases of aplastic anemia the offending agent is identified by inference rather than by proof. Most physicians are understandably unwilling to substantiate the etiology by re-exposing their patient to the suspected agent. It is worthwhile to note the large percentage of cases due to chloramphenicol—20 per cent in our series. In a recent review of 349 cases, 80 or 23 per cent were due to chloramphenicol, which ranked this drug first in known causes of marrow hypoplasia. In this same review 39 per cent were idiopathic as compared to our 33 per cent. A decline from the usual 50 per cent or more called idiopathic in earlier reports may merely reflect a more thorough search in the history for an etiologic agent plus an ever-increasing list of drugs and chemicals known to have caused aplastic anemia. In our series there was no geographic significance. The cases were evenly distributed throughout Georgia, with two cases from South Carolina.

The clinical course as reported by others varies considerably. Some patients have a fulminating course of only a few weeks and others may survive indefinitely. As high as 20-25 per cent are reported to recover completely. In our series 17 are known to have died, the average survival after diagnosis being eight months. Four have recovered completely, and three are still living after 25, 20 and 14 months respectively. Of the four who recovered, it is significant to note that there was primarily leukocyte depression with only mild to moderate erythroid depression. Six patients were not followed by our staff subsequent to their discharge.

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The Control of Influenza

AN EPIDEMIC OF INFLUENZA in its mass effects probably the most dramatic of all epidemiological phenomena. The underlying laws governing the variable severity and periodicity of influenza have challenged medical science for decades. While its virus etiology has been known for more than a quarter century and successful vaccines were demonstrated in 1943, only in the past few years has a nationwide plan for a rational control program been developed. This began in 1957 when the Public Health Service assumed responsibility for coordinating preparations to meet the impending pandemic of Asian influenza.

In 1960, the Surgeon General directed the Communicable Disease Center in Atlanta to embark on a positive program for influenza control on a continuing basis. The program is now entering its second year and is directed primarily at each and every practitioner of medicine in the country. It has been endorsed by an advisory committee consisting of a distinguished group of influenza experts.

The objective of the program is to reduce the serious effects of influenza by immunizing those at greater risk, namely, the aged and the chronically ill. It is a well established fact that an epidemic of influenza is accompanied by a sharp increase in mortality. The causes of excess deaths attributed to influenza include not only pneumonias and other respiratory conditions, but also cardiovascular diseases and a variety of other chronic illnesses. During the three waves of Asian influenza that have occurred in the United States in 1957, 1958 and 1960, a total of 86,000 excess deaths have been recorded. Veritably influenza is a public health problem of major importance.

Prior to 1957, positive action in the control of influenza had been limited largely to the immunization of the Armed Forces personnel and certain key industrial population groups among which sudden increases in non-effectiveness of absenteeism might be critically important. Mass immunization of the public was not deemed justified on the grounds that the uncomplicated disease was self-limited and antigenic variations in prevailing strains of influenza

virus made it difficult to standardize a permanent vaccine.

The present national influenza control program is directed primarily at individuals at high risk rather than selected key population groups. Greatest concern is felt for those who stand to suffer most severely if attacked, or in other words, those in whom an attack of influenza may be limited by death. While there remains some uncertainty over the possible appearance of a new antigenic strain of virus, such new strains usually do not appear more often than once in ten years or longer. When a new strain does appear, the experience of 1957 indicates that it can be incorporated rather promptly in new lots of vaccine.

The essence of the present program is the promotion of annual influenza immunization of the aged and the chronically ill. These include persons with cardiovascular disease, especially those with mitral stenosis or incipient cardiac insufficiency. Individuals suffering from chronic pulmonary disease of any sort, and those with diabetes or Addison disease should be immunized. Pregnant women and all persons over 65 years of age regardless of recognized chronic disease need protection.

The recommended dose is 1.0 cc (500 CCA units) of the polyvalent influenza virus vaccine subcutaneously. Persons who have not previously been immunized should receive a second dose of 1.0 cc approximately two months later. Immunization should be started preferably in the fall months of the year so that the antigenic response will be near maximum during mid-winter when influenza epidemics are most likely to strike. Immunization should be repeated annually.

Much interest has been shown in the possible use of 0.1 cc of vaccine intradermally instead of 1.0 cc under the skin. This procedure is not recommended. Only one-tenth as much antigenic mass can be easily administered in this manner. Intracutaneous inoculations are difficult and often result in much of the inoculum getting into the subcutaneous spaces or leaking out to the surface. The Influenza Advisory Committee does not approve this procedure.

The present national influenza control program is directed especially to the medical profession. No communitywide propaganda or mass immunization campaigns are visualized. However, the immunization of the aged and the chronically ill against influenza should be performed in the private physicians' offices as a routine part of sound geriatric practice comparable to the immunization of children against smallpox, diphtheria, pertussis, tetanus and poliomyelitis that is now a standard of good pediatric practice.

Much concern has been expressed over the prediction that epidemic influenza will appear in the United States during the winter of 1961-1962. Such predictions are far from certain, but they seem reasonably sound in this instance. Influenza A has long tended to recur in cycles of two to three years.

Influenza B recurs every four to six years. The last epidemic of the A type was in 1960 and there has been little of the B type prevalent since 1955. It seems better than a 50-50 chance that one or the other or possibly both types will be epidemic this winter.

The national influenza control program, however, is not geared to any predictions of future epidemics. Rather, its basic philosophy is that annual immunization in the fall of each year will provide the aged and the chronically ill with the maximum protection that medical science can currently offer against the ill effects of influenza whenever it appears.

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Quality Control in the Clinical Laboratory

AS CLINICAL LABORATORY medicine has become more and more important in the diagnosis and treatment of disease, so has the realization that the examinations must be performed with accuracy and precision. Certainly, one of the major factors determining good medical care are good medical laboratory practices.

The proper conduct of a clinical laboratory is based on proper orientation and motivation of the Pathologist, clinician, medical technologist, and hospital administrator. Failure on the part of any one of these is disastrous to the practice of good laboratory medicine. However, we are confronted from place to place with failure on the part of one or the other of the four parties.

The pathologist may fail to supply the direction for quality control. The clinician may not realize the importance of quality control, particularly in his office laboratory or in his referral laboratory.

The acute shortage of well-trained medical technologists may present a serious problem to the development of a quality control program which may be aggravated by failure to instruct medical technology students in quality control.

The hospital administrator may fail, through lack of knowledge or insight into this problem, to approve the acquisition of adequate equipment and personnel.

Quality control means that every series of analyses includes a control sample, which is measured under

the same conditions as the unknown sample. The control sample value is known and a series of analyses is considered "in control" when the control result falls within a certain tolerance.

Quality control certifies the validity of determinations reported by the laboratory.

Accuracy is dependent upon many factors including: (A) The inherent error in the method itself. (B) The error introduced by the use of uncalibrated measuring devices. (C) Incorrect preparation of reagents. (D) Personal errors due to incorrect technique.

A serious effort is being made to bring quality control to all laboratories directed by Pathologists in contrast to commercial and lay laboratories where control is not possible or even desired. The College of American Pathologists and The American Society of Clinical Pathologists have prepared standard solutions and tutorial courses on quality control which are available to all laboratories.

Methods which are used to insure maximum accuracy include:

1. Typed directions for each procedure.
2. Use of control serum.
3. Checking of calculations.
4. Adequate technical supervision by the pathologist.
5. Sound analytical procedures and standards for each series of tests.

Precision refers to the agreement between repli-

cate determinations of a sample, while accuracy refers to agreement between the true value and the determined value. We are primarily interested in precision since the method should not be employed unless it has accuracy. Precision may be expressed in terms of range, average deviation, or standard deviation. Standard deviation is a satisfactory measure of this variability. By a formula the standard deviation of a procedure may be determined. Sixty-eight per cent of values will fall within one standard deviation unit above and below the mean. Ninety-five per cent of the values will fall within two

standard deviations. Ninety-nine and seven-tenths per cent will fall within three standard deviations. Application of this principal will enable the Pathologist to determine the precision of his procedures and the clinician to determine the significance of the result.

Realizing the importance of quality control the Georgia Association of Pathologists awarded a prize to the Georgia Society of Medical Technologists for the best paper written on this subject in 1960.

On page 557 this prize winning paper is published in the belief that it is a significant contribution toward improving laboratory medicine.

John T. Godwin, M.D.

A New Role for Religion in Medicine

ALMOST EVERYBODY likes something new. The excitement which always accompanies a new idea or a new project is like a refreshing summer breeze after a winter of confinement. So it was that the news of a new department in the American Medical Association was recently announced.

The new office known as the Department of Medicine and Religion is headed by the Reverend Doctor Paul B. McCleave, who until a short time ago was pastor of the First Presbyterian Church in Bozeman, Montana.

Among the first organizational endeavors of the new department has been a personal visit by Dr. McCleave with national leaders of 15 major religious denominations in the United States.

The purpose of these visits was twofold: one, the idea that medicine and the clergy shared certain areas of common concern for the total (medical and spiritual) care of the patient had to be explained to national church leaders, and two, the development of programs would be influenced by the results of these visits.

The purpose of this new department within the AMA is to develop two way communications between physicians and clergymen on the national, state and local level; promote understanding on the part of both for the art and practice of the other; and, develop a physician-clergyman rapport to better facilitate the problems, programs and ideas of both groups.

Dr. McCleave has developed a four point program designed to accommodate the needs of both physician and clergyman in their relationships with the doctor's patients and with the clergyman's parishioners.

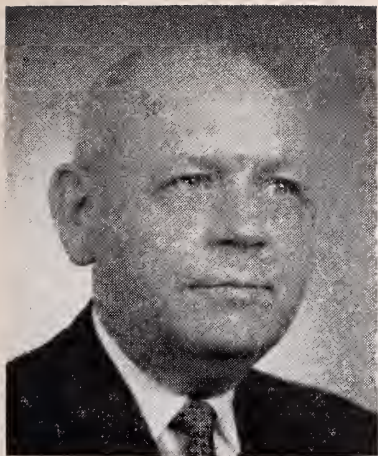
Specifically these points are: (1) the encouragement of closer relationships between physicians and clergymen to the end that better patient care will result, (2) develop leadership teams composed of physicians, clergymen and hospital chaplains to create clinical institutes so that case histories may be presented to select groups of physicians and clergymen, (3) encourage closer relations between local pastors and physician members of their church for the purpose of discussing vital health and spiritual problems, and (4) to prepare articles for church and medical publications.

The creation of this new department will be welcomed by most as a long over due step toward fulfilling a need on the part of both professions.

The encouragement which Dr. McCleave has received from national church leaders signifies their awareness of the need for a nationally coordinated, state endorsed and locally supported program of this type.

It is significant that the initiative to create this new department came from within the ranks of organized medicine. The fact that physicians have been the prime movers in the program is demonstrative evidence of the almost certain success of this new endeavor.

Physicians and clergymen working hand in hand for the common good of the total patient is not a new concept. Such working agreements are as old as the ages. However, a programmed effort on a grand scale, to produce greater achievements, possible only through mass organization, is new. MAG salutes the new AMA Department of Medicine and Religion and commends its program to all physicians and clergymen in Georgia.



PRESIDENT'S LETTER

THE TIME IS HERE AND NOW

FRED H. SIMONTON, M.D.

THE EIGHTEENTH CENTURY British Statesman Edmund Burke is credited with having said that "the triumph of evil requires only that good men do nothing." The circumstances under which he made this remark are of no consequence here. The particular condition to which he was referring has long since passed. What is significant is the timeless truth of this utterance and its irrefutable application to life and society in the 20th century.

The simple truth of the matter is that for too long good men have done nothing outside their own particular professional or business orbit. In the field of government and community responsibility the feeling has pervaded that this is some one else's job and the result has been a dismal utilization of our most talented manpower at a time when the need for our very best is critical.

The hour is late but fortunately there is still time.

The medical profession has been singled out as the sacrificial goat to be offered up on the altar of political expediency by those whose visions of optimum government are at great variance with yours and mine. Many times the proponents of governmental medicine have sought to convert the practice of medicine from a bulwark of free enterprise into a subservient and provincial arm of the Government. Each time they have failed and they will fail in their present efforts to enact the King bill (H.R. 4222) if the forces of medicine will rally to the cause as they have in the past.

We have often heard the saying that it is "now or never." It has been so over worked that it has little meaning left. However, nothing so accurately describes the present legislative picture confronting the medical profession. Literally we are faced with a now or never situation.

In contemplating the problem one must invariably ask the question, what must we do and what can we do to preserve our traditional rights. What course is open to the medical profession to success-

fully resist what amounts to an invasion of its sacred obligation to promote the science and art of medicine and the betterment of public health? Certainly the restrictive bridle of governmental regulations would make this extremely difficult if not dangerously close to impossible.

What We Must Do

First, what we must all do is consider the attempt to pass the King bill as a personal attack on each of us. Having resolved the question that the adoption of this bill is not some remote legislative shenanigan in "far off" Washington but is in fact a close and personal thing we must exert our every effort to convince our patients, our friends, our congressman and our senators that the passage of this bill strikes a violent blow at our basic liberties. We must speak out with evangelistic fervor in support of our right, duty and obligation to treat our patients unmolested by the bureaucratic hand of an impersonal and distant government.

Our task is before us. It is clear cut and well defined. We can accept such crumbs as our detractors would throw our way by shrinking into a corner and piously proclaiming that politics and medicine like oil and water do not mix. Or, we can, as we have in the past, roll up our sleeves, spit on our hands and go to work to make political shambles of those who would threaten the sanctity and independence of American medicine.

Secondly, we must be prepared to make a much larger contribution to the total effort now being waged to defend the profession. This includes, but is by no means limited to, arming ourselves with the facts germane to this issue so that we might be an effective spokesman for the defense of the profession, develop ourselves into forceful and artful letter writers in order that we may spread the gospel far beyond our immediate circle of acquaintances, and above all we must come to grips with the reality that this is a problem which threatens the very continua-

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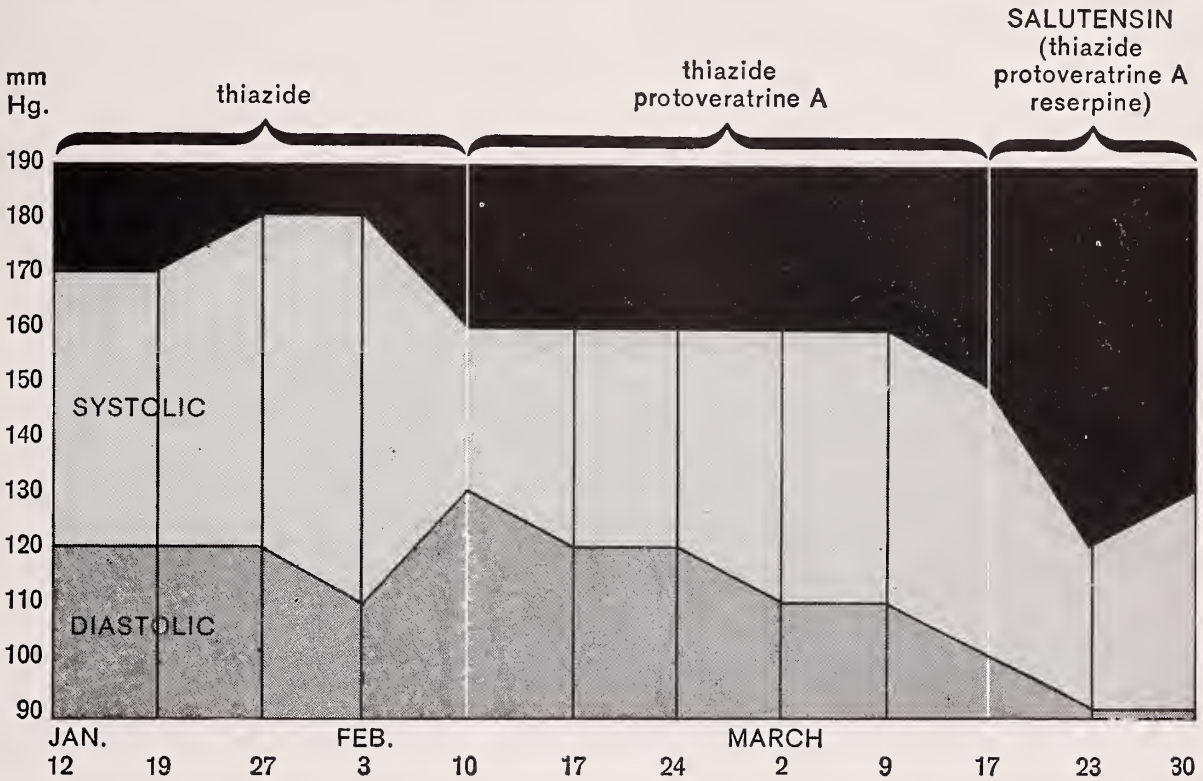
Supplied: Bottles of 60 scored tablets.

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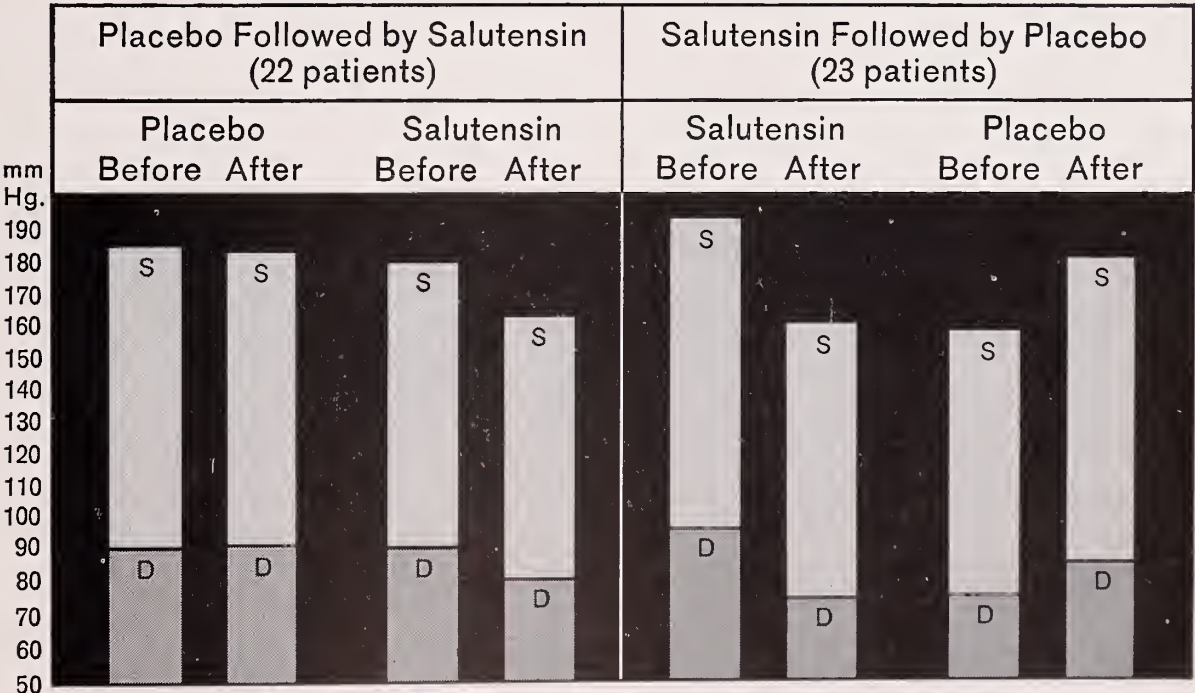
11 WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS BY SERIAL ADDITION OF THE INGREDIENTS IN SALUTENSIN IN A TEST CASE

(Adapted from Spiotta, E. J.: Report to Department of Clinical Investigation, Bristol Laboratories)



3½ WEEKS TO LOWER BLOOD PRESSURE TO DESIRED LEVELS USING SALUTENSIN FROM THE START OF THERAPY IN A “DOUBLE BLIND” CROSSOVER STUDY

Mean Blood Pressures—Systolic (S) and Diastolic (D)



In this “double blind” crossover study of 45 patients, the mean systolic and diastolic blood pressures were essentially unchanged or rose during placebo administration, and decreased markedly during the 25 days of Salutensin therapy. (Smith, C. W.: Report to Department of Clinical Investigation, Bristol Laboratories.)



PRESIDENT'S LETTER / Continued

tion of the medical profession as we have known it.

It will perhaps be recorded as the paradox of the age that the medical profession could be so close to victory and defeat at precisely the same time. Yet, such is unquestionably the case.

The difference between the two now can be measured only by the amount of time, effort and dedication which we doctors will exert in our own defense. To lose after having fought a good battle would be tragic enough, but to lose by default would be catastrophic in the extreme.

In a very recent issue of "Medical Economics" no less an authority than Senator Robert Kerr was quoted as saying that if the Kennedy health plan can be beaten in 1962 that he has high hopes it will stay beaten for some time. Just what the Senator's basis for this statement is I do not know. I do know that it is heartening indeed to hear this

from one so high in the councils of the majority party in Congress. If we fail to redouble our efforts in the face of victory with all that victory means in the years to come, then we will have failed to keep faith with those both in and out of medicine who have made the defense of the profession their personal challenge.

Again, let me repeat, the time is now or never. If we put our shoulder to the wheel during the next few months we can stem the tide which threatens to engulf us. We belong to a generation of challenge. We must meet the challenge or history will not be kind to us, nor will the future be kind to our children.



President, Medical Association of Georgia

MEDICARE NEWS LETTER

Information from Washington

NEW PROVISION—As of the retroactive date of March 1, 1961 immunization parenterally administered against Poliomyelitis and Influenza are authorized benefits under the Departments' Medical Care Program in maternity cases only. Such immunizations are considered, for the purpose of the Medicare Program, to be a part of complete maternity care. Attending physician will be reimbursed for his cost of the vaccine without a statement justifying the cost up to a maximum of \$1.00. Cost above \$1.00 must be supported by a statement from the physician showing justification. Adequate justification must include the manufacturer's name, the attending physician's cost and source of supply.

TEMPORARY PROBLEM—The call up and retention of certain military men is causing difficulty concerning valid identification of these men's dependents who are eligible for Medicare benefits. Any claim paid under the Medicare Program must be supported by a valid Medical Authorization (Identification) Card (DD Form 1173) bearing a card number and covering expiration date. It is the responsibility of the dependent or sponsor to present some tangible evidence, such as, allotment checks, official orders, directives or personal letters which state the pertinent facts to the physi-

cian to help support the dependent's claim of eligibility. However, such information is useful only to show the physician concerned that the dependent is eligible for benefits. Claims from the physician for payment must bear a valid Medical Authorization Card Number and expiration date before payment may be made. It is the duty of the dependent or sponsor to acquire a card and to present it to the physician before the claim is forwarded to the Medical Association for payment. The circumstances outlined above will, of course, cause some delay and confusion for the next several months in the processing of claims. The Medicare Office would appreciate your patience and understanding during these months when services are requested by dependents involved.

General Information

A new claim form to be used in the Medicare Program is now in the process of being printed and will be in use in the coming year. Medicare Manuals will also be available as soon as delivery is made from the Government Printing Office.

The State Medicare Review Board held its Annual Meeting on November 12, 1961 at MAG Headquarters in Atlanta. Problems and policy decisions were discussed. Recommendations of this Board are to be presented before the Executive Committee of Council for approval.



THE USE OF THE PSYCHIATRIC CONSULTANT

Freerk W. Wouters, M.D., *Columbus*

WITH THE GROWING awareness of the scope of the mental health problem and the limitations of the numbers of mental health personnel available, it appears pertinent to consider some of the ways in which psychiatric consultation can be utilized. In general, physicians have little difficulty in recognizing severe mental disorder when they are confronted with it and the need for appropriate referral. There is, however, a wide range of situations where psychiatric consultation can be utilized to the benefit of the patient in addition to the foregoing. Some of these situations are as follows:

1. Mild Psychiatric Disorder. In these situations, which the generalist or internist plans to treat himself, the need for accuracy of diagnosis and appraisal of possible complications and pitfalls is self-evident. For instance, the patient who presents with depressive symptoms, the choice of medication to be employed will rest upon the decision whether the depression is primary or secondary.

2. Coexistent Physical and Emotional Disorders. A common example occurs with the person who has suffered a coronary occlusion and fails to adhere to the regimen outlined by his physician. In this case successful management will not infrequently depend upon recognition of and dealing with the emotional problems present.

3. Inconclusive Findings from History and Examination. In such an instance determination as to whether psychiatric illness is present may be crucial. The ruling out of a functional basis of the complaints in cases of carcinoma of the pancreas or mild diabetes, to name but two conditions among many where this frequently occurs, can be of real service to the patient. Conversely, the dynamics and clinical characteristics of conversion reactions and hypochondriasis are sufficiently well known to permit a clear-cut opinion as to their presence in a large number of cases.

4. Refusal of Needed Surgical Procedures. In this situation psychiatric consultation is seldom resorted to though clearly indicated. In this instance consul-

tation with brief, limited-goal psychotherapy can be lifesaving.

5. Emotional Factors in Elective Surgical Procedures. Evaluation of the motivation and emotional status of patients about to undergo surgical procedures such as gastrectomy for intractable pain, plastic surgery in male patients, hysterectomies, and other sterilization procedures may be valuable in determining whether the procedure will prove of benefit or harm to the patient.

The foregoing, brief and sketchy though it is, does point to some problems where a single psychiatric consultation can be helpful. In using the consultant in this manner, certain obligations are placed upon both the psychiatrist and the referring physician. Let us take the example of the patient who refuses a necessary surgical procedure such as a breast biopsy. In the first place, this patient is obviously resistive to medical intervention of any type, much less psychiatric referral, though an occasion she will welcome consultation as a face-saving mechanism to retreat from an obviously impossible position. With this in mind the referral might be phrased somewhat as follows, "Mrs. Jordan, I am quite concerned about your inability to accept the necessity for surgery and I would like you to discuss this with Dr. Jones, a psychiatrist." At that point the patient should be permitted to react to this statement. Objections on the part of the patient can generally be minimized by pointing out that she is being asked to discuss the problem and not to make a decision. In most cases, the patient will accept a referral on this basis. In communicating with the psychiatrist, the referring physician needs to make clear precisely the reasons for the referral as well as the type of surgery, anesthesia, and probable prognosis. The psychiatrist in turn has the responsibility of sticking to the issue at hand. In this particular instance the patient is probably neurotic, but the consultant is specifically to deal with one symptom, namely that of refusal of necessary surgery. In communicating his findings to the

MENTAL HEALTH PAGE / Continued

referring physician, he should avoid both generalities and issues beside the immediate problem. As far as his findings permit, he should make specific recommendations as in the case of a patient who avoids surgery because he is afraid of "being put to sleep." This may have dynamic implications of interest to the psychiatrist but what the referring

physician needs to know is that his patient is fearful of general anesthesia and that if it is at all possible, the procedure should be done with some other type of anesthesia.

With the growth of clinical knowledge and skills the psychiatrist can render a useful service to his medical brethren which does not always entail a large expenditure of time and is more directly geared to traditional medical practice.

Prepared at the request of the Committee on Mental Health of the Medical Association of Georgia.

CONGRESSMAN DAVIS SPEAKS TO DEKALB MEDICAL SOCIETY



Congressman James C. Davis (right) of Georgia's Fifth Congressional District chats briefly with Dr. L. C. Buchanan, President of the DeKalb County Medical Society prior to the annual dinner meeting of Doctors and Wives of the DeKalb Society.

The Magic of Organization

Speaking before the DeKalb County Medical Society at its November meeting, Congressman James C. Davis said that medical groups and other right thinking conservative elements must learn the magic of organization if they are to reverse the tide of destructive radicalism running in this country.

Addressing the annual dinner gathering of doctors and wives, Congressman Davis told the group that they should enlarge their organized opposition to socialism to encompass more than opposition to socialized medicine.

The day has long passed when individuals "firing from behind rocks and trees as did the minutemen at Concord and Lexington" can hope to succeed against determined organized opposition.

What the Congressman was saying is that neither

medicine nor any other entity can survive in a vacuum, but that it must join forces with other groups dedicated to oppose radicalism in any field. In the absence of such organized efforts the theory of divide and conquer will provide the piecemeal destruction of those who believe in the freedom and integrity of the individual as opposed to the collectivist principles of socialism.

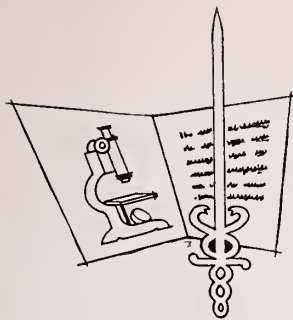
Letters Influence Legislation

Physicians and their wives totaling approximately 130 peoples engaged in a lively and spirited question and answer period with Congressman Davis following his address to the Society. In answer to several questions as to what could the individual physician, his wife or his friends do to influence the course of legislation, Mr. Davis stressed the need for people "back home" to communicate with their representatives in Washington. He classified a person-to-person talk with your congressman or senator as the best method, but added that telephone calls, telegrams and letters would surely not be wasted time and effort on the part of anyone concerned over legislative matters.

The Critical Six Months Ahead

There is substantial support for the idea that the Kerr-Mills approach to the medical needs or our senior citizens should be given a chance to solve the problem before additional legislation is enacted by the Congress. Whether or not this belief represents a majority in the House of Representatives is the great unknown factor in medicine's efforts to defeat Social Security-governmental medicine.

What is known, however, is that the next six months will probably be the most critical faced by the medical profession in a good long time. Nothing short of an all-out effort by every physician in America, working in concert with his friends and others who oppose bureaucratic interference in the practice of medicine will be sufficient to defeat the King Bill. To quote Congressman Davis, "if everyone will put his shoulder to the wheel and his neck in the collar" we can work wonders.



CHEMOTHERAPY OF BREAST CANCER

Wm. J. Pendergrast, Calvin B. Stewart

CANCER CHEMOTHERAPY is still in the developmental stage. Ideas and techniques are changing rapidly, and the practitioner is confused by the number of new drugs and the results claimed for each.

Chemotherapy is playing a more important role in the management of breast cancer. Because of this, now is an opportune time to review the present thinking on drug therapy of this disease. Chemotherapy is useful in the management of breast cancer in all stages; the operable, the inoperable and the recurrent. The agents used may be either the hormones or the other new chemicals which are being developed, including the alkylating agents, the anti-metabolites and the antibiotics.

Operable Breast Cancer

Recent studies have demonstrated showers of cancer cells in the blood stream during surgical manipulation of the primary tumor. This lends support to the idea that cancer is spread by trauma. A cooperative study was begun about four years ago to determine if Nitrogen Mustard or Thio-TEPA given during the operative and post-operative period could reduce the number of recurrences after surgery. The Cancer Chemotherapy National Service Center has recently reported the preliminary results of this study. After a follow-up of over 26 months, the patients treated with Thio-TEPA showed recurrence of cancer only half as often as the patients who received no Thio-TEPA. Chemotherapy was not so effective in other types but may prove to be a valuable adjunct in the management of operable breast cancer. Chemicals have also been used to wash out the surgical wound in an attempt to prevent local implants. The results with Clorpactin, Nitrogen Mustard, Formaldehyde, Zepheran, etc., have been encouraging, but some tissue damage has followed the use of these agents. Experimental studies indicate that thorough copious irrigation with normal saline may be just as effective.

Inoperable or Recurrent Breast Cancer

Women who are inoperable because of their age may require little if any treatment and may live out a normal life span. Combination treatment with hormones and x-ray therapy is frequently satisfactory in these elderly women.

The A.M.A. subcommittee on breast cancer recently reported the results of a 12 year study of 1,983 patients treated with estrogens or androgens. The results indicate that androgens should be used in the premenopausal patients, and that 20 per cent of recurrent breast cancers will get a satisfactory objective improvement. Postmenopausal women are best treated with estrogens regardless of the site of recurrence. About 36 per cent of these cases will get significant regression. If estrogens fail then androgens should be tried. Androgens produce a feeling of well being as well as a protein sparing effect and an increase in the red blood count.

The indications for the use of the cortico-steroids therapy is not completely clear. Medical adrenalectomy can be produced by giving adrenal suppressing doses of the cortico-steroids. Estrogen production by the adrenal gland is suppressed giving a temporary regression of estrogen dependent tumors. This technique has replaced adrenalectomy in some centers while others use it as a test for the effectiveness of adrenalectomy.

The alkylating agents and antimetabolites have been used extensively in the treatment of recurrent breast cancer. Pleural effusion is a frequent complication and responds well to the intrapleural injection of Nitrogen Mustard following thoracentesis. Isolation and perfusion of the breast area has been attempted, but recurrences are usually generalized and require parenteral or oral therapy. The drugs most successfully used are Nitrogen Mustard, Thio-TEPA and Cytosan. There have been many instances of dramatic palliation following the use of these drugs either alone or in combination with x-ray and hormone therapy. Unfortunately, the harm-

ful side effects of these agents limit their usefulness. Many lives have been significantly shortened by the over enthusiastic administration of these toxic agents.

The use of the many new chemotherapeutic drugs

sometimes makes one feel like a cancer quack rather than a scientific investigator. The psychological benefits to the patient and family must not be overlooked, however. In some circumstances we are justified in continuing our efforts even when we realize that they are to no avail. In this regard, the chemotherapeutic agents are frequently useful tools.

Approved by Professional Education Committee, Georgia Division, ASC.

FALLOUT HAZARDS REVIEWED

The Public Health Service said that radioactive fallout levels resulting in the United States up until early November from the new series of Soviet nuclear explosions "do not warrant undue public concern" nor initiation of any special public health action.

The federal agency said that the prevailing levels were not high enough for the public to be concerned about the safety of milk and other foodstuffs.

But PHS added that "continuous, intensive surveillance" by federal, state and local governments was justified.

In a special statement issued after a two-day conference of government and private radiation experts, the PHS pointed out that "very little is known about the effects on animals or humans of very low but prolonged exposures" from either natural background radiation or fallout from nuclear tests.

"The consensus of scientific opinion is that the most prudent course is to assume there is no level of radiation exposure below which one can be absolutely certain that harmful effects may not occur to at least a few individuals when sufficiently large numbers of people are involved," the PHS said. "This is known as the 'non-threshold' concept."

This concept is the basis for U. S. policies and programs for assessment of radiation hazards and for control measures designed to limit exposures of the population, the PHS said and added:

"When this non-threshold concept is applied to present radiation exposure levels being experienced in the U. S. from all sources, including fallout, the following assessment can be made:

"The extra radiation caused by the Soviet tests will add to the risk of genetic effects in succeeding generations, and possible to the risk of health damage to some people in the United States. It is not possible to determine how extensive these ill effects will be—nor how many people will be affected. At present radiation levels, and even at somewhat higher levels, the additional risk is slight and very few people will be affected. Nevertheless, if fallout increased substantially, or remained high for a long time, it would become far more important as a potential health hazard in this country and throughout the world.

"It is the obligation of our Federal and State govern-

ments to undertake all possible measures to assess accurately the public health significance of the present fallout situation, and to prepare for actions to safeguard the public health if these become necessary."

Federal officials said radioactive fallout on the United States will increase next February, March, April and May when the late winter and spring rains wash to earth the remainder of the fallout from the Soviet nuclear tests but it isn't expected to reach a danger level. President Kennedy said any U. S. nuclear tests in the atmosphere would be designed to hold radioactive fallout to an absolute minimum.

The PHS said that the nation's health authorities are giving careful consideration to the possible situations that might require various corrective actions.

"It is evident that an important element of health protection is continuous surveillance and analysis," the PHS said.

"To achieve this, a number of Federal-State systems for public health surveillance, detailed investigation, and radiation control measure have been developed . . . In cooperation with State and local health departments, the PHS operates a nationwide early warning atmospheric radiation surveillance network currently comprised of 58 stations, and a 60-station milk radiation monitoring system. In addition, the PHS has well-established networks for general air and water pollution monitoring with a total of 343 stations. All of these include radiation monitoring among their capabilities and all are being expanded. For example, daily samples of drinking water are being collected in 12 major cities and analyzed for specific radioactive content on a weekly basis, and plans are ready for more extensive monitoring if necessary. Rounding out the PHS resources is a system of highly specialized regional radiological health laboratories.

"The Food and Drug Administration has expanded its program of monitoring the levels of radioactive contamination in foods. Working through 18 District offices and 39 Resident Inspection Stations, its inspectors are sampling goods from all parts of the Nation; particularly those areas where the Public Health Service's air monitoring network has indicated the highest concentration of atmospheric contamination. Additionally, FDA collects samples from selected lots of food being imported into the United States.



HYPERTENSIVE RETINOPATHY FROM THE CLINICAL VIEWPOINT

Joseph A. Wilber, M.D., *Atlanta*

WHEN THE PHYSICIAN with his ophthalmoscope looks at the human fundus, he should be filled with awe at this rare opportunity to see with his own eyes living blood vessels filled with circulating blood cells and living functioning nervous tissue. The pinkish white optic disc is the end of a portion of the central nervous system, the optic nerve. At this point the optic nerve breaks up into multiple fibers which lose their myelin sheath and thus become transparent as they cross the surface of the retina and end in the organs of vision. The central retinal artery divides just below the disc into two main branches, the superior and inferior retinal arteries, which almost immediately branch into a medial or nasal branch and a lateral or temporal branch. The terminal portion of the central retinal artery that we can see within the disc is a true artery with three layers in its structure; namely, an intima, media, and adventitia. However, its branches that cross the retina and which are most obvious to us are peculiar in that they have no middle layer or media. For this reason, they are transparent and show the blood column clearly through their walls. These branches of the retinal artery are unlike any others in the body except for those in the kidney, the afferent and efferent arterioles of the glomerulus which also have this two-layer structure. For this reason many of the common diseases of arteries, in particular atherosclerosis are not seen in the retinal vessels except occasionally in the central retinal artery within the optic disc. It is incorrect, then, to make a diagnosis of "generalized arteriosclerosis" from the appearance of the small vessels of the retina. In fact, it is often noted that patients with advanced arteriosclerosis of the coronary, cerebral, or other large blood vessels will show perfectly normal retinal blood vessels.

There is another peculiarity of the retinal vessels, namely, their marked sensitivity to anoxia. Anything that produces severe or sudden anoxemia of

the retina can cause anatomical disruption of the retinal circulation with the production of hemorrhages and exudates. For this reason, hemorrhages and exudates are seen in a wide variety of diseases. If the anoxia is local, due to obstruction of the central retinal artery or one of its branches, hemorrhages and exudates occur. Or if the anoxemia is generalized as occurs with shock due to massive gastro-intestinal bleeding from a peptic ulcer, or from any other massive hemorrhage, retinal hemorrhages and exudates may be produced. Similarly in severe anemia due to any cause such as leukemia, pernicious anemia, or a nutritional anemia, we may also find diffuse scattered hemorrhages and exudates throughout the retina. Severe hypertension is one of the commonest causes of hemorrhages and exudates in the retina but finding of hemorrhages and exudates should not lead one to conclude that they are always due to hypertension and other causes should be looked for.

The ophthalmologist is a specialist, highly trained in looking at the eye. He would never consider examining the fundus without the eye being properly dilated, the examining room being completely dark, and the ophthalmoscope light being of the proper intensity (for the latter reason he usually prefers an electric ophthalmoscope with a rheostat to control the intensity). This is the best way to see clearly the retinal vessels and perhaps this is why ophthalmologists have derived a classification of hypertensive retinopathy that depends upon fine graduations of changes in calibre and light reflex of the retinal vessels. It is impractical for the average physician to use these classifications unless he duplicates the conditions which the ophthalmologist demands. It is better for the average physician to describe what he sees in general terms such as narrowing and irregular calibre of vessels, hemorrhages, and exudates, papilledema and so forth, rather than to merely put in his record "grade II hypertensive retinopathy." To the casual observer it is nearly impos-

sible to distinguish grade I retinopathy from normal blood vessels. However, there are two frequent types of hypertensive retinopathy which all physicians can easily recognize. The first is a generalized appearance of ischemia of the retina. The fundus looks as though it has very few blood vessels crossing it and those that are visible show a generalized narrowing and straightening. This is often associated with marked distortion of the course of the vein where it crosses the artery; so called A-V compressions. Where the vein and artery cross, they share the same outer lining of adventitia. Thus if there is severe vascular disease in the artery this process may spread to involve the vein. This thickening of the outer layer of the artery obscures the blood column within the vein, making it invisible and giving an impression of compression of the vein. Frequently the vein is twisted and pulled out of its normal course, causing a zig-zag in the appearance of its blood column. The other common picture seen in severe hypertension is a change in calibre of an artery, giving the appearance of a focal constriction. Thus if one follows the course of, say the superior temporal artery across the retina, it will be seen to become markedly narrowed in one spot, and perhaps even disappear, only to re-appear a little further with an irregular calibre in many sections throughout its length. This has been called "spasm" frequently but in chronic hypertensives it has been noted that these "spasms" do not disappear when the blood pressure is lowered by treatment. In toxemia of pregnancy and acute glomerulonephritis, however, this may be true spasm in that often the blood vessels return to normal when the blood pressure becomes normal. This picture of ir-

regular calibre along the course of a single artery is the "hallmark" of hypertensive retinopathy, and indicates severe vascular disease.

Classically, the diagnosis of "malignant hypertension" depends upon the findings of papilledema. However, "malignant" or accelerated hypertension is a clinical syndrome, composed of a marked increase in diastolic pressure associated with rapid decompensation of renal function, usually terminating fatally in uremia within approximately two to four months. This clinical syndrome usually is associated with papilledema, but several cases of pathologically proven malignant hypertension have been seen in which papilledema did not develop. These individuals however, did show severe hypertensive retinopathy with irregularity of calibre and numerous scattered hemorrhages and exudates. If one waits for the appearance of papilledema in such a patient before treating vigorously, it may be too late. The patient with "malignant hypertension" with or without papilledema should be immediately hospitalized and the blood pressure brought to safer levels as soon as possible. This is a medical emergency.

In summary:

- (1) The retinal arteries, with the exception of the central retinal artery, are a poor place to make the diagnosis of arteriosclerosis.
- (2) All hemorrhages and exudates are not necessarily due to hypertension.
- (3) Grades I and II hypertensive retinopathy are difficult to distinguish and confusing in terminology, therefore it is best to describe what one sees, unless one is an ophthalmologist.
- (4) The clinical syndrome of malignant hypertension can occur without the appearance of papilledema.

Prepared at the request of the Committee on Professional Education of the Georgia Heart Association.

PHYSICIANS' RETIREMENT

A NEW BILL TO encourage physicians and other self-employed persons to set up their own retirement plans started through Congress with approval of the House Ways and Means Committee.

Bearing the same number, H.R. 10, as a similar bill which died in Congress last year, the new measure would permit a self-employed person to defer taxes on income placed in a private retirement program. The special treatment would be limited to \$2,500 or 10 per cent of income each year, whichever is smaller.

Such income could be invested in qualified pension

trusts, annuity programs, profit-sharing plans or a new type of non-transferable government bonds redeemable when the individual reaches retirement age or suffers disability.

An individual could start drawing benefits at age 59½, or earlier in the case of disability. A self-employed person would have to start drawing benefits by age 70½.

If a self-employed individual had more than three employees, he would be required to set up pension plans for them before he could benefit himself.



PHYSICIAN'S BOOKSHELF

BOOKS RECEIVED

Bard, Philip, Ed., **MEDICAL PHYSIOLOGY**, The C. V. Mosby Company, St. Louis, 1961, pp. 1339, \$16.50.

Munro, John M., **PRE-NURSING COURSE IN SCIENCE**, The Williams & Wilkins Co., Baltimore, 1961 pp. 147, \$3.50.

Tucker, W. E., M.D., **HOME TREATMENT IN INJURY AND OSTEO-ARTHRITIS**, The Williams & Wilkins Co., Baltimore, 1961, pp. 80, \$3.00.

Leider, Morris, M.D., **PRACTICAL PEDIATRIC DERMATOLOGY**, The C. V. Mosby Co., St. Louis, 1961, pp. 437, \$13.75.

Eastman, Nicholson J., M.D. and Hellman, Louis M., M.D., **OBSTETRICS**, Appleton-Century-Crofts, Inc., New York, 1961, 1230, \$16.00.

Adriani, John, M.D., **ANESTHESIOLOGY**, The C. V. Mosby Co., St. Louis, 1961, pp. 279, \$7.75.

Dripps, Robert D., M.D., Eckenhoff, James E., M.D., and Vandam, Leroy F., M.D., **ANESTHESIA**, W. B. Saunders, Philadelphia, 1961, pp. 413.

Prez-Tamayo, Ruy, M.D., **MECHANISMS OF DISEASE**, W. B. Saunders Co., Philadelphia, 1961, pp. 512.

REVIEWS

Phibbs, Brendan, M.D., **THE CARDIAC ARRHYTHMIAS, A Guide for the General Practitioner**, The C. V. Mosby Co., St. Louis, 1961, \$7.50.

AS THE TITLE IMPLIES, this expanded monograph on the electrocardiographic diagnosis and treatment of cardiac arrhythmias is intended primarily for general practitioners and those physicians and surgeons who have not had special training in EKG or cardiology. The book is divided into five sections dealing with the anatomy and physiology of the conduction system, basic measurements of the EKG, electrocardiographic diagnosis of arrhythmias, clinical notes, and exercises.

The material presented is purposely simplified. The illustrations are abundant and clear and the correlation of the text with the figures is excellent. Author Phibbs was formerly associated with Northwestern University and Cook County Hospital, Chicago; he is presently a practicing cardiologist in Casper, Wyoming.

As I see it the only shortcomings are the omission of the contraindications of carotid sinus massage, the lack of emphasis on the newer techniques of closed chest cardiac massage and external defibrillation. The book can be recommended to that group of the medical profession mentioned above.

James Z. Shanks, M.D.

Wolstenholme, G. E. W. and O'Connor, Maeve, **CIBA FOUNDATION SYMPOSIUM THE NATURE OF SLEEP**, Little Brown & Company, Boston, Mass., 1961, 416 pp., \$10.00.

THIS IS THE transcript of a symposium held on June 27-29, 1960, under the auspices of the Ciba Founda-

tion. As might be anticipated perhaps most of the contributions revolve around the electroencephalogram in various animals under conditions of sleep and arousal. There are, however, interesting studies concerning the relationship between sleep and hibernation, sleep patterns on polar expeditions, the nature of dreaming and effects of prolonged wakefulness on performance and muscle tension. Dr. S. S. Kety has even managed to study the metabolism of the human brain during sleep with results that suggest a slight increase in cerebral blood flow with no change or, at most, a slight fall in oxygen consumption. Verbatim transcripts of the informal discussions add greatly to the value of these symposia.

Thomas Findley, M.D.

Modell, Walter, M.D., **RELIEF OF SYMPTOMS**, The C. V. Mosby Company, St. Louis, 1961, 374 pp., \$11.50.

The major portion of this book discusses the treatments available for the approximately 25 most frequent symptoms encountered in medical practice. Generally it is well done. The author, a pharmacologist and clinician, gives a scientifically critical appraisal of the drugs he discusses, and performs a valuable service in his emphasis on their toxic effects. In spots the book could be improved by brevity, and the well informed reader may find little that is new to him. Nevertheless the average clinician will find this book a worthwhile study of a considerable segment of pharmacology, and will profit by reviewing the different drugs used in the management of nausea, cough, muscle spasm, vertigo, etc.

Although definitive medicine should form the basis of clinical practice, symptomatic treatment of course has its place. A knowledge of the facts contained in this volume will help to make this secondary form of treatment as effective and safe as possible.

Grant Wilmer

Bock, K. D. and Cottier, P. T., **ESSENTIAL HYPERTENSION**, Springer-Verlag, Berlin, Germany, 1960, 392 pp.

CIBA, THE GREAT Swiss pharmaceutical house, has been a pioneer in sponsoring medical symposia. These have been admirable scientific meetings in every way. They assemble from all over the world the leading research workers in a certain field, allow them to present their results and then have open and sometimes heated discussions by the group. They publish the whole thing, including the discussions. All this is done without advertising any of Ciba's numerous pharmaceutical products and in a highly scientific and ethical manner.

This volume describes such a symposium held in Berne, Switzerland from the 7th to the 10th of June in 1960. They gathered together forty specialists in hypertension research from 12 different countries to discuss the many factors in the etiology of essential

PHYSICIAN'S BOOKSHELF / Continued

hypertension. It is very enlightening at times to have a noted authority get up and present a paper, perhaps one you are familiar with from reading the medical literature, and then to hear his responses to the critical questions put to him by an audience of experts. Many times he is forced to agree that different conclusions from those he has drawn are possible from the data presented. Many times he is much less certain in his conclusions than as presented in the paper. For example, in this symposium Sir George W. Pickering gave his now classical paper on the Inheritance of High Blood Pressure. In this study, measurements of casual arterial pressure were made on a sample of the general population and then on a sample of the first degree relatives of patients with essential hypertension. After statistical analysis it was concluded that "blood pressure is inherited, like height, as a graded character, that the inheritance is probably multi-factorial, and the inheritance is of the same range and the same degree over the whole blood pressure range". Sir George stated "the conclusions drawn by us from these studies seem in general acceptable to biometricians and geneticists. They seem in general to be unacceptable to physicians." The next paper by Professor R. Platt from the Royal Infirmary, Manchester, Great Britain, took the same figures and by means of different statistics came to an entirely different conclusion; namely, that there was evidence of two or more distinct populations — a normotensive population and a hypertensive population. In the ensuing discussion by Drs. Pickering, Platt, Schroeder, Grollman, Peart, et al, the real meat of the argument comes out. It is obvious that neither speaker is as certain about his conclusions as it would appear from hearing his paper alone. Perhaps the medical journals might take this idea and print at the end of each paper a short but succinct opinion of it by another worker in the same field, perhaps with a different viewpoint. It is impossible for the general medical reader to be an expert on all of the subjects that he reads and in this way it would be much easier for him to evaluate much of the scientific "opinion" that is published today.

In this symposium, all of the known and suspected factors involved in the disease, essential hypertension (or upper part of the normal distribution curve, as Pickering would say) are discussed in some detail. This includes the role of salt, the adrenal cortex, and renal hemodynamics. In the past few years there have been exciting findings with regard to pressor factors such as Renin and Angiotension; in particular their relationship to the adrenal cortex and the production of aldosterone. However, as Page points out, this is probably the mechanism involved in one type of hypertension only, renal artery occlusion with secondary hypertension. There are many other factors,

neural, chemical, and changes in reactivity and elasticity of the blood vessels which need to be elucidated. Page suggests that all these various facets which compose blood pressure control are in equilibrium with each other and the final pressure level is determined by the equilibrium point. While one facet may temporarily play a dominant role in determining the level, this does not mean that all the other facets cease functioning. "It explains why there are so many possible points in which the mechanisms of blood pressure control can be blocked, for therapeutic reasons. It explains why the clinical picture of hypertension is so variable."

There are excellent discussions of the natural history of hypertension, the pharmacology of some of the newer hypotensive drugs and the diuretics. The survival rates and results of treatment of severe hypertension with both surgical and medical means are also presented.

This is an excellent book for the clinician interested in hypertension and also for the general reader interested in the critical appraisal of medical scientific research.

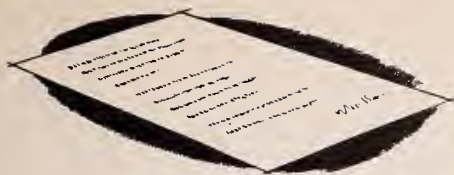
Joseph A. Wilber, M.D.

Coates, John Boyd, Jr., Col., Editor-in-Chief, PREVENTIVE MEDICINE IN WORLD WAR II, VOLUME V, COMMUNICABLE DISEASES, U.S. Government Printing Office, Washington, D. C., 1960, \$5.75, 530 pp.

THIS VOLUME is the fifth in a series recounting the history of preventive medicine in the U. S. Army during World War II. A previous volume has been concerned with diseases transmitted by the respiratory and alimentary tracts. This volume concerns itself with everything else; from leprosy, hookworm, scabies, venereal disease, viral hepatitis, and schistosomiasis among others.

How far from present day reality seem the problems of preventing schistosomiasis in American troops in the Philippines or controlling the venereal disease rate of Negro troops stationed in India, or unraveling the mystery of jaundice following certain batches of yellow fever vaccine. And yet, these were among some of the major problems of control of infectious disease during an era which is far enough in the past now to be looked back on fondly. The lesson, if any, to be learned is that careful, painstaking preparation and planning for the expected and the unexpected is just as important to the medical strategist and tactician as it is for the military. An impressive feature of this volume is the list of contributors who wrote the chapters on the various diseases. This list which reads like a Who's Who of preventive medicine and infectious disease today, consists of men who were only captains and majors in World War II but who cut their teeth on some of the problems described.

Thomas F. Sellers, Jr., M.D.



ABSTRACTS BY GEORGIA AUTHORS

Pearl, Arthur J., M.D.; Ben Woodward, M.D.; and Robert P. Kelly, M.D., Emory University Hospital, Atlanta 22, Georgia, "Cuneiform Osteotomy in the Treatment of Slipped Capital Femoral Epiphysis," *J. of Bone Joint Surgery* 43:947-954 (Oct) 61.

This article is a partial review of the literature and a presentation of a follow up study of 19 patients (19 hips) with slipped capital femoral epiphysis who have had a cuneiform osteotomy. The length of follow up was one and one-half to 12 years with an average of 5.8 years.

The criteria of selection of the patients for this operation were outlined. The operative approach and procedure was described. In the operative description the authors stressed the importance of removing a sufficient wedge and portion of the neck to avoid stretching or tearing the vessels of the posterior synovial covering.

The results were evaluated by observing the alteration in gait, radiographic changes, pain, and the "Index of Hip Function." Ten patients (59 per cent) had good results, one patient (six per cent) had a fair result, and six patients (35 per cent) had poor results.

The need for good exposure, extreme care in preservation of blood supply to the femoral head, adequate wedge resection of the femoral neck, effecting a valgus position of the epiphysis at surgery, proper establishment of the plane of osteotomy, and adequate internal fixation supplemented by external fixation when necessary is stressed.

Greenblatt, Robert B., M.D.; W. E. Barfield, M.D.; E. C. Jungck, M.D.; and A. W. Ray, M.D., Medical College of Georgia, Augusta, Georgia, "Induction of Ovulation with MRL-41," *JAMA* 178:101-104 (Oct. 14) 61

MRL-41, an experimental compound previously shown to have pituitary gonadotropin inhibiting effects in rats, was found to possess the surprising potential for the induction of ovulatory-type cycles in amenorrheic women. The compound is an analogue of a non-steroid estrogen. It was not found to have estrogenic, progestogenic, or androgenic activity.

The effect of the compound was studied in 50 females, 43 of whom were amenorrheic and in the reproductive age range, three of whom were girls with precocious puberty, and four of whom were normally ovulatory.

In two of the normal ovulatory women there was a delay of menses and prolongment of the thermogenic effect of the corpus luteum. This latter finding indicated that MRL-41 has luteotrophic properties.

Of the precociously pubescent girls, all showed regressive changes in the vaginal cytologic response. These signs

plus the occurrence of hot flashes in seven of the amenorrheic women, suggested an antiestrogenic effect of the compound.

Of the amenorrheic women, four were considered to have premature menopause and three were primary amenorrheics. No ovulatory menses were induced in these seven cases. The remaining 36 women were classified as having functional amenorrhea, secondary amenorrhea, or amenorrhea associated with hirsutism. Ovulatory-type menses were induced in 27 (77.7 per cent) of the women.

The salient feature of this drug is its apparent ability to modify pituitary-ovarian balance in the human with resultant induction of ovulatory-type menses. Such an action was evidenced by the secretory changes in the endometrium, the inhibition of ferning of cervical mucus, and the sustained corpus luteum effect, as noted by the prolonged thermogenic response before the onset of menstruation.

McLaren, John R., M.D.; John T. Galambos, M.D.; and H. Stephen Weens, M.D., 80 Butler Street, S.E., Atlanta, Georgia, "Evaluation of Liver Function with Radioactive Iodipamide," *Am. J. of Roentgenol.* 86:768-772 (Oct.) 61.

The authors have studied the course of radioactive iodipamide in two groups of patients. Hospital patients were classified as to whether or not they had liver disease on the basis of clinical and conventional laboratory findings. Following an overnight fast approximately 15 microcuries of radioactive iodipamide in a total volume of approximately one milliliter of iodipamide per 40 pounds of patient body weight were injected intravenously. The hepatic radioactivity was recorded for approximately 15 minutes. The plasma radioactivity was determined after a two hour interval; the urinary excretion of radioactivity, after three and 24 hours; and stool radioactivity, for 48 hour collections.

The following conclusions were made:

1. The hepatic uptake of radioactive iodipamide is significantly depressed in patients with liver disease.
2. The hepatic uptake tracing can be used to predict whether or not opacification of the biliary tree will ensue on subsequent intravenous cholangiography. Those with a definite upward slope will invariably opacify while those with a downward slope will rarely opacify.
3. Significant differences in the urinary and fecal excretion of radioactivity were also noted between the two groups of patients.
4. The per cent of injected radioactivity present in one liter of plasma two hours after the in-

travenous injection did not differ significantly between the two groups.

Birch, Herbert W., M.D., and Donald R. Sondag, M.D., 69 Butler Street, Atlanta 3, Georgia, "Granular-Cell Myoblastoma of the Vulva," *Obst. & Gynec.* 18:443-453 (Oct.) 61.

Granular Cell Myoblastoma is an interesting newcomer to the tumor field and these tumors have been found located in almost every organ of the body. Most of them have been found in the tongue floor of the mouth, lungs, breasts, or skin.

This report presents five instances of vulvar occurrence of granular cell myoblastoma on the Grady Memorial Hospital Obstetrics and Gynecological Service. These tumors were all solitary, benign, and ranged from two to four centimeters in size. It is felt that these tumors should be managed by wide local incision because even though they are benign, local extension is the rule. In the experience of others, inadequate excision has resulted in local recurrences of the tumor necessitating reoperation.

Since the tumors can be of multicentric origin, a thorough search in other regions of the body, particularly in the brain and in the lungs should be made, and every patient that has the diagnosis of a granular cell myoblastoma of one site on the skin anywhere, should have a thorough neurological examination, skull films, and a chest x-ray.

Greenblatt, Robert B., M.D.; Medical College of Georgia, Augusta, Georgia, "Chemical Induction of Ovulation," *Fertility & Sterility* 12:402-404 (Sept.-Oct.) 61.

This article reviews briefly the few methods of therapy which have provided some hope for induction of ovulation in the human female. Successes in this area of reproductive physiology have been meager.

The author reports the induction of ovulatory-like menses in several amenorrheic women by the oral administration of chloramiphen*, a compound structurally related to the non-steroid estrogen, TACE. In addition to the induction of menses, this compound brought about a thermogenic shift in basal temperature which lasted from 14 to 21 days. Endometrial biopsies obtained during the luteal phase of the cycle were secretory in type. Some patients noted the occurrence of dysmenorrhea and premenstrual molimina for the first time.

The manner of action of chloramiphen* must be further investigated. At this time it would seem evident that chloramiphen* is a pituitary modifier. No estrogenic, progestational, or glucocorticoid properties have thus far been noted. Possible anti-estrogenic ef-

CONCEPTS / Continued

fects or action mediated through the central nervous system were suggested by the fact that some patients experienced hot flashes during administration of the drug. No untoward effects have thus far been noted on the hematopoietic, renal, or hepatic systems.

* Since publication of the original article, the generic name has been changed from chloramiphen to *clomiphen*.

Godwin, John T., M.D.; Pyrrha Grodman, M.D., and Miriam Smiley, 265 Ivy Street, N.E., Atlanta 3, Georgia, "Correlative Study of Pathologic and Cytologic Specimens in Carcinoma 'In Situ' of the Cervix," *South M.J.* 54:1120-1123 (Oct.) 61.

The results of cervicovaginal cytologic studies and a correlation of quadrant biopsy, conization and hysterectomy specimens are presented.

The information obtained in this study indicates that routine application of cervicovaginal cytologic studies greatly enhances the yield of curable cervical carcinoma. It also is established that when dependable cytologic interpretations are available and of easy

access, they are used by clinicians. Of great importance is the convenient location of the laboratory to referring physicians for discussion and consultation with the pathologist and consistent survey of the case material as it is presented.

This review suggests that the properly planned study of an individual with no apparent cervical lesion should be cervicovaginal cytologic studies, quadrant biopsies, conization and hysterectomy. Of course, this sequence need not be inflexible, and will vary with certain cases. It is apparent that these studies merely confirm generally accepted concepts about cytologic studies and demonstrate what is being done in a single geographic area not previously reported upon.

This study reaffirms the importance of conization for determining the extent of the lesion and the fact that even then an occasional infiltrating lesion may escape detection until the hysterectomy specimen is examined.

Rumble, Lester, Jr., M.D.; A. R. Gholson, M.D.; J. A. Bordon, M.D.; E. Lee Fry, M.D.; Raymond Tenenbaum, M.D., 83 Baker Street, N.E., Atlanta 8, Georgia, "Twelve Months Experience in Anesthesia in a 300 Bed Gen-

eral Hospital," *South M.J.* 54:1059-1068 (Oct) 61.

In this presentation, the authors present their system of record keeping in anesthesia as a means of improving anesthetic management. Rarely is a statistical report of the activities of "trained" anesthesiologists published in the literature. Rather, most of the evaluations come from training institutions and probably do not represent a true picture of what occurs in the practice of this specialty.

In this paper is included a copy of the monthly report form utilized in this hospital, made out by each individual, and tabulated annually for comparative purposes. This form is so constructed as to serve as an interesting month-to-month comparison for each individual member of the department, as well as to collect accurate data for annual statistical reports.

Good medical practice demands well-kept records. In general, slipshod practice goes hand-in-hand with slipshod records. Good reports point the path to better diagnosis and offer a reminder of errors or inadequacies in management and therapy. A part of the purpose of this paper is to try to instigate a similar type of record keeping by all trained anesthesiologists.

PUERTO RICO FACES MEDICO-POLITICAL CRISIS

The first hurricane of the 1962 season to blow out of the Caribbean is likely to scotch tradition and bear a man name, and judging from present tropical storm warnings will kick up a wind to make "Hattie" look like a gentle summer breeze.

Hurricane Arbona will hit the Puerto Rican Legislature in January with wide spread damage to the medical profession and the quality of hospitalization anticipated.

Dr. Guillermo Arbona, Puerto Rico's Health Secretary has submitted his Arbona Plan to nationalize the island's health services and the legislature controlled by the Popular Democratic Party appears to be in a receptive mood.

The nationalized health service as the Arbonaists estimate will cost \$44.4 million per year with an average cost per patient of \$11. The Plan would be financed through increased taxes to yield \$20 million from various levels of government, \$13 million from employers, \$9 million from employees, and \$2.4 million from property owners and those who collect dividends from securities.

The Puerto Rico Medical Association under the leadership of Dr. Enrique Perez Santiago has challenged the proponents of this scheme declaring that a general lowering of standards in hospitalization and medical care will be experienced if the legislature adopts this nationalized health plan.

Dr. Santiago also accused the government of being unrealistic insofar as the \$11 per patient figure is concerned. As he pointed out the figure is more apt to be \$15 per patient. This will mean that the total cost of

the program would be \$60 million per year rather than \$44.4 million—a 25 per cent increase over the Arbona estimates.

The 1960 decimal census credits the Commonwealth of Puerto Rico with a population of only 2,349,544 persons. Assuming that Dr. Santiago's figures of \$15 per patient is correct, the per capita cost of this program would come to a whopping \$25.54 per year for every man, woman and child in Puerto Rico.

To fully comprehend the enormity of these figures apply the base of \$25.54 to the population of the United States (approximately 180 million) and the cost of a similar program here would come to \$4,597,200.00 per year. Similarly, if such a program were instituted in Georgia it would cost the taxpayers \$100,707,182.64 per year.

By limiting the extent of government participation to those who actually need help, Puerto Rico, like Georgia and other States could accomplish the job of caring for her people for considerably less than the Arbona Plan will cost.

Puerto Rico, like Georgia and indeed the entire United States will be able to have a reasonable hospital and medical care program only so long as their respective economies can stand up under the strain. Basic economics will tell even the most naive that an unwarranted and unreasonable drain on fiscal resources will do more than any other one thing to make impossible the necessary medical program which the indigent must have.

1961-62 CALENDAR OF MEETINGS

State

- Jan. 23-25—Obstetric Problems In Private Practice, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- Feb. 13-15—Cardiac Emergencies, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- Feb. 18-21—Atlanta Graduate Medical Assembly, Atlanta Biltmore Hotel, Atlanta, Georgia.**
- Mar. 20-22—Pre and Postoperative Care, Medical College of Georgia, Augusta, 18 hrs. Cat. I.
- April 2-4—Augusta Postgraduate Medical Assembly (Coincides with practice rounds of the Masters Golf Tournament) Augusta.
- May 6-9—Annual Session, Medical Association of Georgia.**

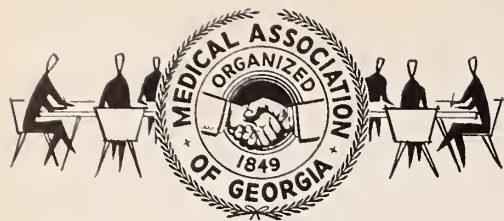
Regional

- Mar. 5-8—Southeastern Surgical Congress, Louisville, Ky.
- Mar. 12-15—New Orleans Graduate Medical Assembly, The Roosevelt Hotel, New Orleans.
- Mar. 18-21—Missouri State Medical Association, St. Louis.
- Mar. 26-28—American College of Surgeons, Sectional Meeting, Hotel Peabody, Memphis, Tenn.
- April 8-11—Tennessee State Medical Association, Peabody Hotel, Memphis, Tenn.
- April 23-25—Annual Meeting West Virginia Academy of Ophthalmology and Otolaryngology, Greenbrier Hotel, White Sulphur Springs, West Virginia.
- April 26-28—Alabama, Medical Association of the State of, Tutwiler Hotel, Birmingham, Ala.
- April 29-May 2—Arkansas Medical Society, Arlington Hotel, Hot Springs, Ark.
- May 5-9—Medical Society of North Carolina 108th Annual Meeting, Sir Walter Hotel, Raleigh.
- May 7-9—Louisiana State Medical Society, Hotel Frances, Monroe, La.
- May 8-10—Mississippi State Medical Association, Hotel Heidelberg, Jackson, Miss.
- May 8-10—South Carolina Medical Association, Ocean Forest Hotel, Myrtle Beach, S. C.
- May 9-13—Florida Medical Association, Americana Hotel, Miami Beach, Bal Harbour.
- May 12-15—Texas Medical Association, Austin, Tex.

National

- Jan. 17-19—Tenth Postgraduate Course, American Diabetes Association, The Statler Hilton, Detroit, Mich.
- Jan. 18-20—American Society of Clinical Radiology, Arizona Biltmore Hotel, Phoenix, Ariz.

- Jan. 19—American Society of Facial Plastic Surgery, Hotel Elysee, New York City.
- Jan. 26-27—American Society for Surgery of the Hand, Palmer House, Chicago.
- Jan. 27-Feb. 1—American Academy of Orthopaedic Surgeons, Palmer House, Chicago.
- Feb. 3-6—Congress on Medical Education and Licensure, Palmer House, Chicago.
- Feb. 5-7—American Academy of Allergy, Denver-Hilton Hotel, Denver, Colorado.
- Feb. 7-9—American Academy of Occupational Medicine, Pittsburgh-Hilton Hotel, Pittsburgh, Pa.
- Feb. 7-10—American College of Radiology, Roosevelt Hotel, New York, New York.
- Feb. 8-10—Society of University Surgeons, Cleveland, Ohio.
- Mar. 20-23—American Association of Anatomists, Minneapolis, Minn.
- March 21-24—Neurosurgical Society of America, Buena Vista Hotel, Biloxi, Mississippi.
- March 30-April 1—American Society for the Study of Sterility, The Drake Hotel, Chicago.
- March—American Otorhinologic Society for Plastic Surgery, Philadelphia.
- April 1-6—American College of Allergists Graduate Instructional Course and 18th Annual Congress, Hotel Radisson, Minneapolis.
- April 2-14—Postgraduate course in Laryngology and Bronchoesophagology, University of Illinois College of Medicine, Chicago.
- April 2-5—American College of Obstetricians and Gynecologists, Palmer House, Chicago, Illinois.
- April 6-13—American Academy of General Practice, Las Vegas, Nev.
- April 9-12—Aerospace Medical Association, Atlantic City.
- April 9-13—American College of Physicians, Bellevue-Stratford Hotel, Philadelphia.
- April 16-18—American Association for Thoracic Surgery, Chase-Park Plaza Hotels, St. Louis.
- April 23-28—American Academy of Neurology, Statler-Hilton Hotel, New York City.
- April 30-May 2—American Academy of Pediatrics, spring meeting, Statler-Hilton, New York City.
- April 30-May 3—American Proctologic Society, Deauville Hotel, Miami Beach.
- April—American Association of Pathologists and Bacteriologists, Queen Elizabeth Hotel, Montreal, Canada.
- May 6-10—American Association of Plastic Surgeons, Hotel Del Coronado, Del Monte, Calif.
- May 28-30—American Ophthalmological Society, The Homestead, Hot Springs, Va.
- May 29-June 2—American College of Cardiology, Denver Hilton Hotel, Denver, Colo.



THE ASSOCIATION

DEATHS

HOWELL ANDERSON WASDEN, JR., 47 of Pavo died October 16, 1961 in an automobile accident. He was a graduate of Mercer University and the Medical College of Georgia. Dr. Wasden served with the U.S. Army from 1945-1947.

He was owner and superintendent of Willis Wasden Hospital in Pavo and was on the local school board. He was a member and deacon of Pavo Baptist Church, a member of the Thomas-Brooks Medical Society, the American Medical Association, and the Second District Medical Society.

He is survived by his wife, Alice Medlock Wasden; a son, Howell Anderson Wasden, III; two daughters, Carole and Marjorie Ann Wasden; three brothers, Dr. Harry Wasden of Quitman, Dr. Charles N. Wasden of Macon, and William Wasden of Millen.

E. LEE FRY of Atlanta died at the age of 40 at his home on October 23, 1961. Dr. Fry was a graduate of the University of Georgia Medical School and of Berea College in Kentucky. He served two tours of duty with the U. S. Navy before setting up a practice in Macon. Three years ago he moved to Atlanta and was associated with St. Joseph's Infirmary.

He was a member of St. Martin-in-the-Fields Episcopal Church in Atlanta. Dr. Fry was also a member of the American Medical Association, the Fulton County Medical Society, the Medical Association of Georgia, and the American Board of Anesthesiologists.

His survivors include his wife Anne Harris Fry; two daughters, Mary Elizabeth and Martha Regina Fry; a son, David Lee Fry; his parents, Mr. and Mrs. H. L. Fry of Dillard; two sisters, Mrs. James Deal of Knoxville, and Mrs. Bert H. Moore of Mount Pleasant, S. C.; two brothers, James C. Fry of Alexandria, Va., and Ray M. Fry of Evanston, Ill.; and his grandmother, Mrs. H. C. Fry of Clarksville.

WILLIAM POSEY SMITH, SR., of Bowdon, died at the age of 95 on October 27, after a lengthy illness. He had practiced medicine for more than 50 years and 30 of those years were on crutches. Dr. Smith attended Bowdon College and was graduated from the School of Medicine-University of Georgia in Augusta in 1899.

He was an honorary member of the American Medical Association, a member of the Medical Association of Georgia and the Carroll-Haralson-Douglas Medical Society. He was a member emeritus of the Bowdon Masonic Lodge.

His survivors are his wife, Felicia Adams Smith; three daughters, Dr. Louise Smith of Tallahassee, Fla., Miss Oren Smith of Bowdon, and Mrs. G. W. Hammond of Newnan; one son, Dr. W. P. Smith, Jr. of Douglasville; and three grandchildren.

HERSCHEL ATTICUS SMITH, SR., 70, of Americus died November 7, 1961 following an illness of some

months. He received his medical degree from the Atlanta College of Physicians and Surgeons in 1914. He did his internship at Grady Hospital in Atlanta before setting up his practice in Americus. Dr. Smith was a captain in the Medical Corps during World War I. Dr. Smith then returned to Americus where he practiced medicine for more than 42 years.

He was a Fellow in the American College of Surgeons and the International College of Surgeons, the Southern Medical Association, the Southeastern Surgical Congress, the Medical Association of Georgia, the American Medical Association, the Third District Medical Society, the Sumter County Medical Society, and the Medical Association of Georgia. Dr. Smith had been a steward in the First Methodist Church as well as a trustee. He was a charter member and past president of the Americus Kiwanis Club and a director of the Citizens Bank of Americus. Last February he was honored with an Accolade of Appreciation good citizen plaque from the Americus and Sumter County Chamber of Commerce.

He is survived by his wife Cora Lee Morgan Smith; a daughter, Miss Mary Lee Smith of Atlanta; a son, Herschel A. Smith, Jr. of Americus; four brothers, James, Orin, Wilbur Smith of Williston, Fla., and Carl Smith of Jacksonville, Fla.; and four grandchildren.

SOCIETIES

BALDWIN COUNTY MEDICAL SOCIETY had Dr. Gabriel D'Amato of Augusta and Savannah as their guest speaker during their October meeting. He spoke on the Difficult Problems in Out-Patient Psychiatry.

CARROLL - DOUGLAS - HARALSON MEDICAL SOCIETY elected their new officers the first of November. They are: Martin L. Johnson, president; R. D. Allen, president-elect; F. W. Morgan, vice president; and J. H. Beall, secretary-treasurer.

COWETA COUNTY MEDICAL SOCIETY recently saw a film on closed chest cardiac and respiratory resuscitation.

DeKALB COUNTY MEDICAL SOCIETY recently had C. E. Pattillo as guest of honor at their October meeting. The guest speaker that night was R. Hugh Wood, former dean of the Emory University Medical School.

DOUGHERTY COUNTY MEDICAL SOCIETY elected John S. Inman, Jr. as their new president. Other officers include F. Dempsey Guillebeau, vice president and Ben Giles, secretary-treasurer.

GEORGIA MEDICAL SOCIETY had Darrell Coover from the American Medical Association as their guest in November. He is the national director for the speakers bureau for the AMA.

GLYNN COUNTY MEDICAL SOCIETY's October meeting consisted of reports from several committees. Of special interest was the report of the Medical

Legal Committee who stressed the importance of understanding between the two professions.

HABERSHAM COUNTY MEDICAL SOCIETY had J. C. Thoroughman, Chief Surgeon of the Veterans Hospital address them in October.

HALL COUNTY MEDICAL SOCIETY and the Gainesville Ministerial Association had a joint meeting in November in an effort to broaden areas of cooperation and understanding between clergymen and physicians.

POLK COUNTY MEDICAL SOCIETY elected in November Charles Rogers, president; Harold Goldin, vice president; and T. E. Cummings, secretary-treasurer.

STEPHENS COUNTY MEDICAL SOCIETY re-appointed M. D. Pittard as chairman of their School Child Health Committee.

TROUP COUNTY MEDICAL SOCIETY recently saw a new film from the American Cancer Society that has not been released to the public. The movie which related to cancer of the rectum and colon met with the approval of the Society members as satisfactory for the release to the lay public.

WARE COUNTY MEDICAL SOCIETY had Marvin F. Engel present a paper on Pre-Malignant Lesions of the Skin at their November meeting.

PERSONALS

First District

ROBERT PENCE and ROBERT ROBINSON of Metter moved into their new office building the first of last month.

CARL H. BRENNAN of Savannah was recently elected a fellow of the American Academy of Pediatrics.

Second District

HARRY A. WASDEN of Quitman was recently the "Personality of the Week" in the local newspaper.

Third District

W. G. ELLIOTT and ROBERT MARTIN have returned to their practice after an absence due to illness.

A. B. CONGER of Columbus was the guest speaker at the November meeting of the Columbus Lawyers Club.

ROBERT PENDERGRASS of Americus was the featured speaker at the Methodist Men's Club "Ladies Night". He spoke on Andersonville.

Hawkinsville doctors were the hosts recently for the Fall Meeting of the THIRD DISTRICT MEDICAL SOCIETY.

Fourth District

J. T. MITCHELL and K. D. GRACE of LaGrange are acting directors of the West Georgia Cancer Clinic.

Fifth District

A. H. HUNT of Lithonia has recently moved into his new office building on the Covington Highway.

WILLIAM ROTTSMAN of Atlanta spoke on the progress made in Georgia's mental health program in October to the Georgia Institute On Mental Health.

THE FIFTH DISTRICT MEDICAL SOCIETY elected L. C. BUCHANAN of Decatur as their president, CARL JONES of Atlanta secretary-treasurer,

FLOYD R. SANDERS, JR. of Decatur councilor, and LAWRENCE P. MATTHEWS of Decatur vice councilor.

Sixth District

HUGH K. SEALY of Macon was the guest speaker at the Men's Inter-Civic Club Council recently. His subject, "Heart Attacks".

RICHARD S. OWINGS has joined the Staff of Jefferson Hospital, Inc. of Louisville, and has his office in the hospital.

F. T. McELREATH, JR. of Tennille attended the postgraduate course in pediatrics at the Medical College of Georgia in November.

Seventh District

New officers of the Tanner Memorial Hospital Medical Staff in Carrollton are: HAROLD McLENDON, chief of Staff, PHIL ASTIN, vice-chief of staff, and HARVEY BEALL, secretary.

LEE H. BATTLE, JR. of Rome spoke recently to the Rome Junior Chamber of Commerce.

DAVID A. WELLS of Dalton recently attended the postgraduate course in pediatrics at the Medical College of Georgia.

Eighth District

The Wayne County Medical Society was host recently to the EIGHTH DISTRICT Medical Meeting in Jesup. Elected were: LANIER HARRELL, Jesup, president; JOHN DUNCAN FARRIS, Waycross, vice president; NEAL YEOMANS, Waycross, secretary.

Ninth District

W. D. STRIBLING, III of Gainesville was recently honored with the WDUN Citizenship Award.

H. M. NEWMAN, III of Gainesville, D. T. DARNELL of Tate, WESLEY W. HARRIS of Royston, and M. D. PITTARD of Toccoa attended the postgraduate course in pediatrics at the Medical College of Georgia recently.

Tenth District

RAMON THOMPSON of Athens was speaker at a recent meeting of the Medical Staff at Morgan Memorial Hospital in Madison.

WALTER L. SHEPARD of Augusta has recently been elected to the board of directors of the American Society of Clinical Pathologists.

FRANK ANDERSON of Augusta spoke on "A Christian View of Marriage" to the Westminster Fellowship in Talmadge Hospital Nurses' Residence.

ALBERT G. LEROY of Thomson attended the postgraduate course on pediatrics recently at the Medical College of Georgia.

EXECUTIVE COMMITTEE OF COUNCIL MEETING

THE EXECUTIVE COMMITTEE of Council meeting was called to order at 10:00 a.m. by Acting President Linton H. Bishop.

Those attending the meeting were: Linton H. Bishop, Atlanta, First Vice President; George H. Alexander, Forsyth, Chairman of Council; Milford B. Hatcher, Macon, Immediate Past President; Thomas W. Goodwin, Augusta, President-Elect; John T. Mauldin, Atlanta, Secretary; J. G. McDaniel, Atlanta, Chairman of Finance. Guests present were David R. Thomas, Augusta; and John T. Godwin, Atlanta. Staff members present were Mr. Milton D. Krueger, Executive Secretary; Mr. James M. Moffett,

Assistant Executive Secretary; and Mrs. Catherine Wooten, Executive Assistant.

Mr. Krueger read the minutes of the Executive Committee meetings of September 17 and 21. These were approved as read. He reviewed the Council meeting minutes of September 16-17.

Minutes Procedure

The reading of the minutes was discussed by the Committee. In order to clarify the procedure for reading the minutes at each meeting, on motion (Hatcher-Alexander) it was voted that the minutes would not be read in full at the time of the meeting, but that the minutes would be sent to each member of Council at the time of the mailing of the agenda for the subsequent meeting, with a note to bring the minutes to the next meeting.

Hospital Licensure, Construction and Indigent Care Council

After discussion regarding non-attendance at past meetings of this Council, on motion duly made and seconded, it was voted to ask the Chairman of MAG Council to write the MAG representatives to orient them as to what is going on and urge their attendance at future meetings.

Resolution on C. Raymond Arp

This Resolution was read by Mr. Krueger as prepared by Dr. A. H. Letton. On motion (McDaniel-Alexander) it was voted to send a copy of the Resolution to the family with the statement that it was prepared by Dr. Letton and approved by the Executive Committee, and that the names of the Executive Committee be put on the Resolution.

Appointment of MAG Annual Session Scientific Exhibits Chairman

It was suggested that three names be submitted to the Annual Session Chairman Peter Hydrick. On motion (McDaniel-Hatcher) it was voted to appoint Drs. McDaniel, Bishop and Mauldin as a committee, with Dr. Mauldin as Chairman, to contact Dr. Hydrick, and after consultation the committee to be empowered to make the appointment.

MAG Resolution No. 1 Report

Secretary Mauldin read correspondence received from the Atlanta and Columbus Blue Shield groups regarding coverage of certain professional services under Blue Shield. On motion (Hatcher-McDaniel) it was voted to ask the Secretary to send a copy of this correspondence to the Presidents of the Specialty Societies concerned, with a covering letter that MAG would be glad to reconsider this matter if the situation in the hospitals is changed.

President's HEW Regional Meeting

Secretary Mauldin reported on a meeting to be held in Nashville, Tennessee, November 9-10, 1961, and read a letter from the Tennessee State Medical Association regarding the meeting. On motion (Hatcher-McDaniel) it was voted to refer this matter to the President, Chairman of Council and Secretary for further study and action indicated along the lines discussed at this meeting, with Executive Committee approval, if indicated.

AMA Hospital Accreditation Letter

Secretary Mauldin read a letter from the AMA regarding the state associations incorporating a symposium on Joint Commission on Accreditation of Hospitals in their annual meeting programs, and that County Medical Societies devote one meeting to this problem. On motion (Mauldin-McDaniel) it was voted to write a letter to the County Medical Societies, with a copy to AMA to recommend that the societies comply with the request in this letter.

Treasurer's Report

Mr. Krueger gave the Treasurer's report. On motion (Mauldin-Hatcher) the report was approved as read.

Headquarters Office Report

Mr. Krueger gave a report on the employment of personnel. This report was received as information.

Paramedical Personnel Project

John T. Godwin gave the Executive Committee information regarding a proposed training program for medical technologists. He asked for support and assistance in obtaining funds to get the program under way. On motion (Mauldin-Hatcher) it was voted to endorse the program.

MAG Annual Session AMA Guest Speaker

Secretary Mauldin read a letter from Dr. Hugh Hussey, who has accepted the MAG invitation to be guest speaker at the 1962 Annual Session in Savannah.

This portion of the meeting was recessed at 12:35 p.m. for luncheon.

The meeting was reconvened at 1:15 p.m. and business proceeded as scheduled.

Medical Assistance to the Aged Program Implementation Report

Secretary Mauldin gave background information on this program. He asked for Executive Committee decision on the disbursement of funds for consultative services to be sent to the Association effective October 1, 1961 until January 1, 1962. On motion (Hatcher-Alexander) it was voted that the Medical Director be paid \$1,000.00 per month for providing necessary consultative services under the provisions of the contract to begin October 1 through December 31, 1961, and that the Association should bill the State Department of Public Welfare for this amount.

Report of Insurance and Economics Board

Chm. David R. Thomas stated that the Life Insurance Company of Georgia desired to increase their rates. There was general discussion about this item. On motion (Goodwin-Alexander) it was voted to authorize Dr. Thomas to write the Life Insurance Company of Georgia to submit actual facts and figures to substantiate their request for increase in premium rates.

Unfinished Business

Secretary Mauldin reported on the following items:

(a) Automobile Tax Deduction: Report was received as information.

(b) MAG Resolution No. 3: Report was made on the activities of other states on this Resolution.

(c) MAG Charter Revision: The Charter has been revised and was received for information.

(d) Clayton Hospital Problem: This report was received as information.

(e) MAG Representatives' Attendance at Nurses Meeting: Secretary Mauldin stated J. Frank Walker would attend a nurses' group meeting in Salisbury, Maryland, October 26.

New Business

(a) Date and Site of November Executive Committee meeting: November 19, 1961, 10:00 a.m., at Association Headquarters, with luncheon at the building.

Relative Value Study Committee Recommendations

Chairman Harry Pinson made the following report: The Relative Value Study Committee adopted a Relative Value Schedule per the California Relative Value Study with co-efficiencies, for recommendation to the State of Georgia employees health insurance plan.

The Committee also recommended that this plan have a deductible clause for hospitalization and recommended that the payments for physicians' services be made directly to the physician and that it be emphasized that this is an *indemnity program* and that this recommendation is to be revised in the future as the MAG study indicates. On motion (Mauldin-McDaniel) it was voted to accept the coefficient figures and recommendations of the Relative Value Study Committee.

There being no further business the meeting was adjourned at 3:30 p.m.

EXECUTIVE COMMITTEE OF COUNCIL NOVEMBER 19, 1961

THE EXECUTIVE Committee of Council meeting was called to order at 10:15 a.m. by President Fred Simonton, Chairman.

Those attending the meeting were: Fred H. Simonton, Chickamauga; Thomas W. Goodwin, Augusta; George H. Alexander, Forsyth; Linton H. Bishop, Atlanta; J. G. McDaniel, Atlanta; and John T. Mauldin, Atlanta. Guests present were Eustace A. Allen, Atlanta; R. W. Edenfield, Macon; John M. McCoy, Atlanta; John P. Heard, Decatur; Mr. H. V. Lamon, Attorney; and Mr. Frank Shackelford, MAG Attorney. Staff members present were Mr. Milton D. Krueger, Executive Secretary; Mr. James M. Moffet, Assistant Executive Secretary; and Mrs. Catherine Wooten, Executive Assistant.

The invocation was given by Dr. Goodwin.

On motion duly made and seconded it was voted to dispense with the reading of the minutes of the last meeting and so approve them as published.

Discussion of Health Department Proposed Legislation

President Simonton discussed recodification of Georgia public health laws. It was suggested that a Committee of the President, Chairman of Board on Legislation and the MAG Attorney meet to look over the laws as soon as they are available and make a decision on each in order to work with the Health Department. It was also suggested that this item be placed on the Council agenda for the December meeting so that these recommendations might be made to the State Board of Health for guidance in this recodification plan. Mr. Krueger was asked to get the names of the legislators on the committee drafting the codification of the public health laws.

AMA Board of Trustees Report

Dr. Allen reported that it had been proposed that the AMA Board of Trustees to be increased to 15. He asked Executive Committee's decision as to how he should vote on this proposal. On motion (Mauldin-Alexander) it was voted that the Executive Committee of the Medical Association of Georgia go on record as being opposed to the enlargement of the AMA Board of Trustees unless the enlargement is on a regional basis.

The Cuban refugee physician problem was discussed.

He emphasized the AMA's desire to keep the fight against the King-Anderson bill active.

Disability insurance through the AMA was discussed.

Dr. Allen asked for resolutions to be submitted to the House of Delegates at the AMA Clinical Session in Denver. No Resolutions were submitted.

Appointment of MAG Treasurer

Dr. McDaniel stated that the committee of Drs. Mauldin, Bishop and McDaniel had talked with Dr. John S. Atwater, who was interested in the position. On motion (Goodwin-Alexander) it was voted that Dr. Atwater be recommended as MAG Treasurer, to be confirmed by Council, and that he would assume office January 1, 1961.

Treasurer's Report

Acting Treasurer McDaniel submitted this report. On motion (Alexander-Mauldin) it was approved as presented.

MAG Attorney's Statement

Drs. McDaniel and Mauldin discussed the charge for professional services in connection with the drawing up of the contract between MAG and Department of Public Welfare. On motion (Alexander-McDaniel) it was voted to approve the attorney's fee for payment.

MAG Awards Report

Dr. Bishop discussed recommendations on the method of presenting the MAG Awards as follows:

(1) Hardman Award (for scientific attainment) with nine man secret committee appointed by the President, with the two deans of the medical schools as members and the President of MAG as Chairman.

(2) Distinguished Service Award: The President of MAG to appoint a ten man district secret committee, after nominations have been received by MAG Headquarters.

On motion duly made and seconded it was voted that the Executive Committee should recommend to Council at the December meeting, the above recommendations for changing the method of presentation of MAG Awards, for Council's decision.

Appointment of MAG Annual Session Scientific Exhibits Chairman

Secretary Mauldin reported that upon the recommendation of the MAG Annual Session Board Chairman Peter Hydrick, Edgar Grady, Atlanta, was submitted for consideration. On motion (Goodwin-Alexander) it was voted to approve the appointment of Edgar Grady as MAG Annual Session Scientific Exhibits Chairman.

Report of HEW Regional Meeting, November 9-10, Nashville

Dr. Mauldin and President Simonton reported on this meeting. This report was received as information.

Resume of Medicare Meeting

Mr. Mauldin gave a report on the State Medicare Review Board Meeting of November 12, 1961 and discussed the recommendations as follows:

(1) The need for an objective plan for adjudication of Special Report Claims; (2) Rotation of Review Board Members; (3) Remuneration of Review Board Members for travel expense; (4) Formulation of new boards according to frequency of claims; (5) Policy concerning physicians' complaints of Review Board adjudications. On motion (McDaniel-Goodwin) it was voted to accept the recommendations of the Review Board, and to recommend Council approval of the renegotiation of the contract with no specific changes.

Kerr-Mills Welfare-MAG Implementation Program

Medical Director Mauldin gave a report on the present status of the program and read the plan of operation. It was requested that a copy of this plan be sent to each member of Executive Committee.

The meeting was recessed at 12:35 p.m. for luncheon.

The Executive Committee meeting was reconvened at 1:10 p.m.

Formation of Professional Association Groups Under Recent Georgia Law

John M. McCoy, Atlanta, stated that he and Dr. Heard, along with his attorney, were present to ask continued support of the Georgia Professional Association Act. There was general discussion on this subject. On motion (Goodwin-Mauldin) it was voted to assure the professional groups of MAG continued interest.

Pension For MAG Employees

The pension plan was discussed by the Executive Committee and taken under study.

December Council Meeting

Mr. Krueger asked for good representation at the December Council meeting and at the Thomas-Brooks Medical Society meeting and social hour.

AMA Medicine-Religion Program

Mr. Krueger gave the AMA proposed program between Medicine and Religion: (1) 15 national denomination leaders to be contacted by Reverend Paul McCleave of AMA; (2) State Associations to have meeting between representatives of both professions; (3) County Medical Society Medicine-Religion meetings on local level to be held; (4) Religion to take initiative with physician members of respective churches; (5) Literature and articles to be traded by two professions. The entire program is for the betterment of patient care and will be instituted on a trial basis in four states. This report was received as information.

Headquarters Office Report

Mr. Krueger described personnel plans for processing claims for assistance with the Kerr-Mills-Welfare-MAG Implementation Program.

Unfinished Business

Dr. Mauldin read a draft of a letter to the hospitals in Georgia, which would accompany the plan of operation to the

Kerr-Mills Welfare-MAG Implementation Program. This was approved as read.

New Business

(a) President-Elect Goodwin read a letter from Claude-Starr Wright, M.D., Professor of Medicine and Director, Department of Continuing Education of the Medical College of Georgia, regarding continuing medical education in Georgia. Dr. Goodwin suggested that this letter be referred to the Board of Medical Education with instructions to invite Dr. Wright to the next Board of Medical Education meeting; and Dr. Simon-ton suggested that the same letter be referred to the GAGP Committee on Medical Education.

(b) Secretary Mauldin read the message of thanks from the family of Dr. Arp for the Resolution sent by the Executive Committee.

(c) Georgia Public Health Officers Meeting: Secretary Mauldin stated that the Public Health Officers had requested the MAG exhibit at their meeting April 30-May 2, 1962. This would necessitate the expenditure of \$5.00 to put on the exhibit entitled "Nutrition Nonsense and False Claims," which is the

AMA's newest exhibit. It was suggested that this be referred to a committee composed of Drs. McDaniel, Mauldin and Bishop for investigation and decision.

(d) President Simonton asked for a form letter to be written to the families of deceased MAG members, but after general discussion it was decided that there was no sure way of getting all the names. The deaths of those members, about whom MAG is notified, are written in the Obituary column of the JMag.

(e) Revision of workmens compensation fee schedule was discussed. This matter had previously been referred to the Insurance and Economics Board.

(f) Economic Stabilization Conference: MAG was requested to send a representative to this Conference, December 5-6, 1961. It was suggested that the Secretary choose a representative and notify Mr. Goodman, who made the request.

(g) Lt. Gov. Byrd letter: Secretary Mauldin's letter was approved as read.

(h) MAG 1963 Annual Session Headquarters Hotel: President Simonton stated he had been requested to ask consideration of the Buccaneer Motel, Jekyll Island, as headquarters hotel for the 1963 MAG Annual Session. It was recommended that this be referred to the Local Arrangements Committee for consideration.

(i) Date and Site of December Executive Committee meeting: The decision on this matter was left to the President.

There being no further business the meeting was adjourned at 3:20 p.m.

Remember These Dates for Your Calendar

MAY 6-9, 1962

These are the dates for the

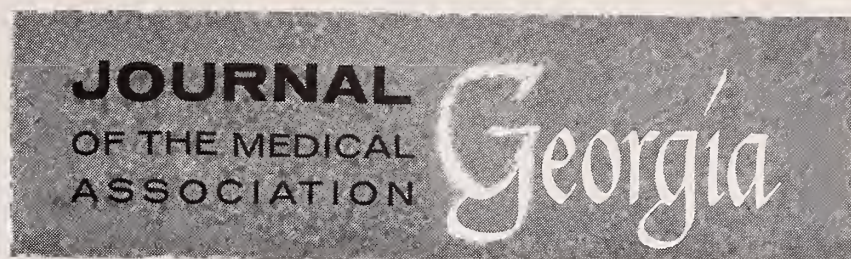
ANNUAL SESSION

of the

**MEDICAL ASSOCIATION
OF GEORGIA**

to be held in

SAVANNAH, GEORGIA



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